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ABSTRACT

Objectives of the project described in this report were to (1) determine the nature of changes occurring in the role of health care administration; (2) ascertain the causes of the roles; (3) develop recommendations for the initial and continuing education of health care administrators; and (4) note barriers to role implementation. Chapter 1 presents a general narrative summary of the study and itemizes the conclusions reached. The second chapter delineates the profile of the hospital chief executive officer, while the third chapter reviews the literature relevant to the research and develops a role model of the chief executive officer. Chapters 4 through 6 analyze data related to meeting the project's objectives: chapter 4 analyzes the results of a questionnaire distributed to a sample of hospital, long-term care, clinic and health maintenance organization administrators, with results pertaining particularly to objectives 1 and 2; the fifth chapter reports data obtained in open-ended discussion interviews with selected groups of administrative leaders concerning changing issues in hospital administration; and chapter 6 reviews the data related to the educational needs of health services administrative personnel. The last chapter discusses future challenges and barriers to the implementation of role changes and educational development. A forty-page appendix describes the methodology of the research questionnaire and presents samples of questionnaire forms used in the research. (BL)

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AN INVESTIGATION INTO THE NATURE, CAUSES, AND IMPLICATIONS OF THE FUTURE ROLE OF THE HEALTH CARE ADMINISTRATOR

The Final Report
for
Contract Number 231-75-0004
Bureau of Health Manpower
Health Services Administration
Public Health Service
U.S. Department of Health, Education, and Welfare

March 31, 1977

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U.S. DEPARTMENT OF HEALTH
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PREFACE

This research project was conducted under Contract Number 231-75-0004 from the Bureau of Health Manpower, Health Resources Administration, Public Health Service, United States Department of Health, Education, and Welfare with the Board of Regents of the University of Wisconsin System through the School of Business, University of Wisconsin-Madison. The objectives of the contract were to: (1) determine the nature of changes occurring in the present and future role of health care administration; (2) ascertain the causes of the present and anticipated roles; (3) develop recommendations for the initial and continuing education of health care administrators--objectives, kinds of skills required, possible problems of implementation and research; and (4) note barriers to role implementation.

Chapter I presents a general narrative summary of the study and itemizes the conclusions reached. The second chapter delineates the profile of the hospital chief executive officer; while the third chapter reviews the literature relevant to the research and develops a role model of the chief executive officer. Chapter IV analyzes the results of the questionnaire distributed to a sample of hospital, long-term care, clinic and HMO administrators. The fifth chapter reports data obtained in open-ended discussion interviews with selected groups of administrative leaders. Chapter VI reviews the data related to the educational needs of health services administrative personnel. The last chapter discusses future challenges and barriers to the implementation of role changes and educational development.

Thanks are extended to Mr. William Holland, Assistant Chief, Manpower Utilization Branch, Division of Associated Health Professions, Bureau of Health Manpower, who, as Project Officer, willingly devoted time and expert advice in bringing the project to fruition. The many interviewees and questionnaire participants cannot be recognized individually, but without their willing participation, the work of the research team would have been impossible. We extend our thanks and gratitude to those individuals.

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TABLE OF CONTENTS

CHAPTER PAGE

I. Health Services Administration: Present and Future.......... 1

II. A Profile of the Hospital Chief Executive Officer........... 21

III. The Field of Health Services Administration: Historical Perspective.................................. 59

IV. Survey of Health Services Administrators.................... 133

V. Changing Issues in Hospital Administration.................. 233

VI. Education for Careers in Health Services Administration..... 293

VII. Challenges for the Future................................... 339

APPENDICES

A. Methodology: The Research Questionnaire..................... 361

B. Questionnaire Forms Used in the Research.................... 401

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AN INVESTIGATION INTO THE NATURE, CAUSES, AND IMPLICATIONS OF THE FUTURE ROLE OF THE HEALTH CARE ADMINISTRATOR

CHAPTER I

HEALTH SERVICES ADMINISTRATION: PRESENT AND FUTURE

Extensive changes have occurred in the health services delivery system in the United States over the last 20 years. The next 20 years appear to hold similar promise of substantial change in the health services delivery system, as man continues his struggle to control his environment and to improve the quality of life. The challenges of the future for improved health services will focus, at least in part, on improved distribution and utilization of the resources devoted to health. Thus, the health services administrator will likely play an expanded role in the future delivery of health services as increased complexity demands more active management. This report describes anticipated changes in health services administration, their causes, and their implications.

The research project, "An Investigation into the Nature, Causes, and Implications of the Future Role of the Health Care Administrator," is a study of the role of health services administrators at the present time, and of the anticipated changes which will occur in the role in the next 10 to 15 years. The project was divided into a number of phases, including an extensive literature review, interviews with hospital administrative personnel, and with "role senders"--that is, individuals external to the hospital who are influencing what happens within the hospital setting; and with educators. Additional phases included an extensive questionnaire to health services administrators in hospitals, clinics, long term care facilities and health maintenance organizations, and the use of a modified Delphi instrument with those previously interviewed.

This chapter is organized into three major sections. The first section is concerned with the nature of the future role of the health services administrator. The second section is concerned with the causes of the future role of the health services administrator, and a third section discusses some implications of the future role of the health services administrator. The objective of this chapter is to summarize the findings and recommendations of the project.

SUMMARY OF MAJOR FINDINGS OF THE RESEARCH

1. The standards of the Joint Commission on Accreditation of Hospitals and the Guidelines for Bylaw Preparation of the American Hospital Association are a major influence upon the job descriptions of hospital chief executives.

2. Interpersonal relationships, motivation of subordinates, and the initiation of change were presently the most time consuming and important roles for hospital administrators, and their future importance was expected to remain high.

3. Interpersonal relationships, including community leadership, outside of the individual hospital, and decision-making regarding external negotiations will become more important in the future.

4. Determination of goals and objectives was consistently reported as presently the most time consuming and important activity and was expected to remain most important in the future for hospital chief executives.

5. Financial management was the second most time-consuming and important activity at present for hospital chief executives.

6. Government-related activities will become the second most important activity for hospital chief executives in the future.

7. Operational management activities will decrease in importance in the future while externally-oriented activities will increase in future importance for hospital chief executives.

8. Tasks involving policy issues, senior level personnel management, and external affairs are those which hospital chief executives perform most frequently themselves.

9. Tasks involving basic level personnel management, the provision of patient care, and basic support tasks such as maintenance, safety, and purchasing programs are those which hospital chief executives most consistently delegate.

10. Tasks related to financial management and standard operating procedures are sometimes delegated and sometimes performed directly by the hospital chief executive officer.

11. Role senders from within organizations, such as administrative staff and medical staff, are reported as having more influence on the chief administrator on average than role senders outside the organization.

12. In the future, the influence of health planning agencies and the federal government is expected to increase greatly.

13. Quality patient care, recruitment and retention of professional staff, development of harmonious interpersonal relations among staff, cost containment, and good community relationships are among the five most important goals for hospital, long-term care, and clinic administrators.

14. Almost two-thirds of the hospital administrators believe their role will change, while only about one-half of long-term care, clinic, and HMO administrators expect a change in role.

15. Few differences exist across institutional settings in the managerial roles when broadly defined role categories are employed.

16. Hospital administrators emphasize policy related tasks and external representation, while clinic administrators engage in more operational activities, especially of a financial nature.

17. Administrators of larger hospitals rated policy activities higher in time consumed, importance, and anticipated importance, while administrators of small hospitals considered internal management more important in each category.

18. Long-term care administrators rated roles involving motivation and interpersonal relationships, and initiation of change as most important now and in the future.

19. Clinic administrators gave high ratings of present and anticipated importance to motivation, change initiation, information gathering, and negotiation roles.

20. Policy matters, senior level personnel management, and external affairs are the types of tasks which hospital and long-term care administrators perform directly themselves.

21. Regularly delegated tasks for all administrators include basic personnel program duties and patient care related activities.

22. No clear cut patterns of differences by education emerged.

23. The role of the hospital as an autonomous institution is changing.

24. Increased regulatory control and expanding intervention by external groups is causing increased complexity within the hospital.

25. The administrative role will involve more external "political" contacts with legislators, community groups, and agencies external to the hospital.

26. Community needs should be the inspiration for hospital policy formulation.

27. The health services administrator will become more of a resource manager for the community in the future.

28. Hospitals will need specialization and will need to develop alternative service formats.

29. Multi-hospital systems are one possible strategy for dealing with future changes in health care.

30. The image of the hospital will evolve into a center for health care and community health education, which will in turn involve the marketing of hospital services.

31. Ambulatory care developments and a resultant need for administrators will be important issues in the future.

32. Horizontal and vertical integration of health services are two means to deal with the increasing complexity of health services.

33. Delphi respondents anticipate major changes in cooperative decision-making, alternative delivery systems, and development of a public utility model for health care.

34. Delphi respondents generally agreed that governmental control, management delegation, and administrative specialists are increasing.

35. Major skill areas identified included: financial acumen, coordination, human relations, external political knowledge, communications, strategy, marketing, planning, and analytical and negotiating skills.

36. Administrators were reported as needing: an analytical mind, a good self-image, confidence, the ability to organize, tolerance for conflict and ambiguity, the ability to make decisions with uncertain information, and knowledge of personnel, accounting, and medical functions.

37. Experience is important for the student before he enters his administrative studies.

38. Substantial experience is necessary in a variety of hospital functions before an individual advances to a chief executive position.

39. Four components of educational programs are identified in a health management education model--including general societal knowledge, management skills, a specialization area, and specific subsystem knowledge.

40. Skills in human relations and interpersonal relationships, in accounting and finance, in planning, in negotiating, and in communication are especially important for administrative personnel.

41. The most important areas of study identified by Delphi respondents included: financial management, administration of health care institutions, nature of the health care system, administrative decision-making, and the economics of health.

42. The structure and organization of residency programs need further analysis.

43. The area of continuing education is perhaps one of the most neglected and uncoordinated aspects of health administration.

44. There is no real consensus about continuing education, other than that it will be more critical in the future.

SUMMARY OF MAJOR FUTURE CHALLENGES FOR HEALTH CARE ADMINISTRATION

1. The increasing external involvement of chief executive officers.
2. Standards of accountability and clearly defined responsibilities.
3. Coordination and cooperation between different health delivery system units.
4. Horizontal and vertical integration.
5. Task allocation between the chief executive officer and his administrative staff.
6. Utilization of middle management specialists in finance, personnel, risk management, systems engineering, purchasing, etc.
7. The development of a community medicine/preventive medicine orientation.
8. The balance between cost containment and high quality patient care.
9. The composition of health organization boards of trustees.
10. Understanding the needed health industry-specific components of educational programs.
11. Understanding individuals' motivations to engage in continuing education.
12. Continued research and analysis in administrative role delineation.

THE NATURE OF THE FUTURE ROLE OF THE HEALTH SERVICES ADMINISTRATOR

The role of the health services administrator is continually evolving. Initially, medical specialists--physicians or nurses--administered hospitals. An early evolution of the role saw the hospital administrator become a business manager. At a later time, he became a coordinator or integrator of the various services of the hospital. Presently, the hospital administrative role is shifting toward that of a planner for the institution as it meets community needs.

External Involvement of the CEO

Two extreme viewpoints characterize the anticipated future role of the hospital administrator: first, increased regulation may lessen the need for management within the individual hospital, as outside control of decisions expands. Thus, the local administrator's job might be little more than implementation. Alternately, the ongoing changes due to increasing federalization may open new areas and new challenges. A middle-of-the-road position may be more accurate--the external involvement of the chief executive officer will likely increase which will lead to a specialization between the chief executive who will focus on external relationships, and a chief operating officer who will focus on internal operations. Thus, the future role of the hospital administrator will require more external relationships in addition to internal management activities.

Inter-Hospital Cooperation

Interviewees suggested that inter-hospital competition has decreased, that group decision-making and group planning among hospitals must be fostered, and that many institutions are evolving toward a health maintenance type organization. Yet, in contrast, over 83% of the questionnaire respondents indicated no plans to add a health maintenance organization to their institutions' programs.

More systematized relationships must be developed between and among health care organizations due to cost-related issues and to governmental pressures for delivery of more and better services. Coordination is needed in dealing with the regulations, in bargaining with unions, and in the development of satellite clinics and regional health care organizations. A trend towards regionalization is a likely short-range innovative development and perhaps within 15 years the entire country will have 100 to 150 very large regional health care organizations. Management contract arrangements with outlying or satellite hospitals, mergers leading to economies of scale and multi-hospital chains or consortia arrangements are other potential developments. More institution based medical services and more physicians on the paid hospital staff are other possibilities.

Evaluation of Services

The future role of the hospital administrator will entail increased evaluation of the services offered. Many interviewees hoped that health planning would become more closely controlled at state and community levels, but some interviewees suggested that hospitals will gradually be brought under a public utility model. The fear was expressed that national health insurance would create a demand for health services which could not be met due to current planning regulation restrictions.

Governance

Corporate forms will likely be the norm in health care governance. Because of this, there will be more members of the management team and more physicians serving as board members. Some felt that most decision-making will move to the management team or to the management council of the hospital. Some role senders suggested that consumer and/or citizen advisory boards may play an increased role in the decision-making process for hospitals and that the goals for administrators were changing and should include such things as how to expand the organizational base and how to relate outside the hospital institution. These interviewees felt that too little research had been done in defining the proper role of the hospital administrator, and that there were not enough skilled administrators to meet the potentially increasing demands.

The need for more aggressive management, willing and able to exploit the economies of scale on an inter-institutional basis is critical as is the need for confidence and the willingness to take risks. Resistance to change is a problem for health care administrators and many other health care workers including physicians. Rethinking organizational patterns and the position of the hospital administrator will be important issues for future administrators. The chief executive officer must determine his course of action in light of many conflicting demands and must become a more effective decision maker with more data points at his fingertips.

THE CAUSES OF THE FUTURE ROLE OF THE HEALTH SERVICES ADMINISTRATOR

One approach to determining the causes of the changing and future role of the health services administrator--particularly the hospital administrator--is to assess the issues facing administrators at the present time. This section summarizes particular issues which appear to be actively demanding administrative attention.

Changes in the Health Care System

The integration and development of a comprehensive health care system is a constantly raised theme. A critical question is whether or not the hospital will be the core of that comprehensive health care system. Horizontal affiliations, more shared services (including transportation facilities), alternate uses of space, and the medical campus idea involving vertical integration of a number of different types of health care institutions will undoubtedly be future issues as will the costs of medical care and national health insurance. The direction of health care system changes is affected directly by governmental involvement in health care and by the recognition that the distribution and utilization of resources are not now adequate.

In meeting community needs, administrators must be more proactive, rather than reactive, and have the consumers' interests and the health of the community as goals, rather than merely dwelling upon disease and inpatients. Comprehensive health planning would be less of a problem if these were the goals. Many health care administrators are concerned with planning, however, and planning will be very important in the future. Corporate planning is necessary because the penalties for poorly defined goals, objectives, and accountability at any one time are too light.

The Costs of Health Care

Concern about cost issues was expressed, but most frequently by those directly involved with paying for health care. Inflation and increases in capital costs lead to an emphasis on cost and rate regulation in the future, and the financing of health care will be more closely scrutinized. New techniques and products must be examined for cost-effectiveness. The doctor is one key problem in the financial area. Cost containment and quality appraisal should involve more than the medical staff, including the board, administration, and medical staff jointly.

Government Regulation of Health Care

The increased role of government is an important recent change in health care administration. Hospitals are concerned about future government controls, and hope to achieve desirable positions before controls are imposed. Some administrators truly resent controls and bureaucratic actions which interfere with their own freedom of choice and action, but governmental intervention and regulation will likely continue. Judicial intervention in decision-making is another issue; health policies are subject to increasing scrutiny by the courts. These factors force careful thought and analysis on an expanding number of issues according to those interviewed.

Alternative Forms of Health Care Delivery

In the future, the hospital administrator will compete with larger group practices for out-patient services. Clinics may be the appropriate center for preventive medicine and transportation services to bring patients to the clinic may be one alternative delivery method. Ambulatory care, nursing home care, and so forth, will increase as will the pressure for insurance reimbursement for these services. Planning officials were especially interested in ambulatory care, with accompanying insurance reimbursements. Third party payers may be altering the control of the medical profession over the form of health delivery. Alternative forms of health care delivery will undoubtedly change the needs for various health care professionals and these changes must be considered in the planning process.

Evaluation of Health Care

Quality assurance is another major need. Data availability, standards and criteria for analysis, and the comparison of outcome data across different populations all are important issues confronting administrative personnel. The demands for evaluation represent one more example of the generally increasing complexity of health services administration.

This increasing complexity of the field and of its administrative roles is a dominant theme in the post-World War II period. The 1970's have seen a renewed interest in the economics of the health industry as increased costs, the recession, higher transfer payments, declining birthrates, and quality review all contribute to increased concern by the public over health costs. Along with this concern over costs have come increased federal and state regulatory activities as well as more active discussion of national health insurance. These changes, together with more political and community involvement, have made the position of the chief executive officer more complex. Along with the increased complexity in the position of the chief executive officer has come increased accountability. Formerly, the chief executive officer was accountable only to his board, and in some cases to the community. Today, he is responsible to a variety of publics, as well as to the board.

The Changing Role of the Hospital

A major cause of the changing administrative role is the changing role of the hospital itself. To summarize, the role of the hospital has changed from a place where people went to die, to one where health is recovered, to an evolving role of improved community health, unrelated to whether or not the person is a patient. There are many indications of these changes and further changes will occur so that the hospital serves the consumer as a member of the community concerned about his health. The health system is in a state of change, which will result in a new and different format than exists at present. How soon it will come, and the exact nature of the new format, will depend on consumer demands, and how well administrators and other health care personnel can meet these demands without unduly increasing regulations to insure compliance.

IMPLICATIONS OF THE FUTURE ROLE OF THE HEALTH SERVICES ADMINISTRATOR

Given the prior discussion of the nature and causes of the future role of the health services administrator, what are the implications? This section identifies and summarizes the salient implications stemming from the project.

Organization Structure

There is substantial agreement that the health delivery system of the future will be different from that of today. Combinations, mergers, affiliations, or consortia agreements among institutions seem most likely. Such developments are already in progress, either in the form of management contract agreements or satellite and outreach programs. Trends toward a central medical care unit with other outlying units serving as feeders to the central unit, and toward more corporate structures and multi-hospital chains appear likely in the future. Regardless of the particular modifications to the health delivery system, there will undoubtedly be more shared services among institutions and more region-based health care with perhaps 100 to 150 major regional health care corporations and other institutions as units of the regional corporations.

It is obvious, then, that there will be new organizational structures and new organizational relationships developing as far as hospitals and other health care facilities are concerned. At this time it is difficult to completely foresee the configuration of these organizational structures, but an increased trend towards vertical and horizontal integration of health care delivery units is one clear implication.

External Relationships

The chief executive officers of institutions will be involved in more external relationships and will become the external representatives of their organizations in the community. The fiscal situation of health care units will remain relatively tight and, if inflation continues, may become even more severe. Thus, cost controls, cost consciousness, and cost containment programs will become very important for the chief executive officer. More cost-effective health care will be emphasized in the future.

Additional Middle-Level Administrative Specialists

The addition of more middle-level administrative specialists is another implication for the future. Sophistication and analysis capabilities in many areas will increase, and the administrator will need specialized personnel to deal with these areas. In turn, the administrator will face greater tension than has been present in the past, unless he can effectively delegate to subordinates and involve them more in the decision-making process. Involved with this administrative specialization will be an increased tendency for hospital managers to hold positions on their board of directors, following the corporate model. As the service orientation and the need of the hospital to work with community resources increases, there will be more emphasis on outreach and community relations. Administrators will become more involved in community and regional health planning, and will become more proficient in this area.

Marketing Activities

The need for the hospital to market its services and the concept of health care is another implication. These marketing activities will involve new specialists and new activities for chief executive officers. The fact that many hospitals may play feeder roles to other parts of the system will require substantial interorganizational relationships with new modes of operation and greater challenges for the administrator. The administrator must be primarily a strategist and an external contact person who must have great flexibility, move with the times, and gain more knowledge about total operations and interrelationships in the entire health care system. The administrator will be more involved in coordinating and overseeing the activities of the management team. Thus a crucial skill needed for the future is an understanding of the behavioral sciences, human relations, motivation, and the ability to maximize the efforts of other people.

Graduate Education

An emphasis upon a functional area of concentration in graduate programs for health services administrators is emerging. This concentration could be in accounting, finance, data processing and information systems, industrial relations, engineering, purchasing, risk management, and so forth. The rationale behind this trend is that the student needs some particular skills for the first job, so that a direct contribution to the organization is possible. Furthermore, many hospitals are becoming so complex, that it is almost impossible for the new graduate to become an assistant or associate administrator and be effective without considerable prior experience. Some programs are resolving this problem by requiring students to have or obtain some experience prior to entering the graduate program.

Health services administration programs for the future may have four major components:

1. The development of knowledge of the general societal environment.
2. The development of management skills, including interpersonal relations, planning and data-based decision-making skills.
3. The understanding of the health industry, especially as an integrated health services delivery system.
4. An area of specialist or functional concentration.

Health professionals external to the hospital indicated that students should definitely be given a broader systems orientation than they now receive. The administrator needs to be knowledgeable about the entire health system, and about the interrelationships which exist between different health care delivery units. Administrators of the future will need more skills in conceptualizing the organization's role in the community. Especially important for administrators will be understanding strategy, and the identification of the options available to the institution.

Continuing Education

The need for continuing education to deal with new and different issues is another major implication of the changing administrative role. Comments about continuing education ranged from those suggesting that better programs of continuing education are needed through evaluative comments--such as, the current system does not offer very good continuing education to a generally expressed desire for continuing education programs. Time is a critical factor for many administrators in their selection of continuing education programs. One-year fellowships or leaves-of-absence were not desirable in the eyes of some interviewees. The two- to four-day conference also received some criticism, as did the instructional forms in which one faculty member lectures to a large group of administrators.

Continuing education programs must be suited to the needs of the people who participate in them, but how this is to be done is not at all clear. Some administrators suggested that continuing education was strictly an individual effort, and that because many organizations are small, costs restrict them from participating in continuing education activities. Again, however, the theme is heard that top management should encourage continuing education, should themselves conduct continuing education programs, and that in fact continuing education should be a requirement for continued participation in management. The implications of the continuing education practices and needs of administrators may be especially important as change and active management become more important for health services organizations.

Ports of Entry

There was general agreement that the Master's programs in health services administration should continue to offer a generalist education. What was not so clear, however, was the kind of ports of entry job the generalist would have upon entering the hospital or other health care institution. In the past, many administrators assumed assistant and associate level types of positions; today, however, this is not always possible due to the complex nature of the hospital. The need for some functional skill area in the educational program is apparent so that initial port of entry jobs may be in a specialist area--such as in purchasing, personnel management, accounting, and so forth. There may still be some generalist positions, such as manager of the outpatient department or the admissions department, which might serve as appropriate first jobs for a new graduate. Needless to say, consideration must be given to what are proper port of entry jobs for graduates of programs as the health care system increases in size.

Residency

In order for graduates to readily assume second or third level positions, the residency may continue to be an important requirement, or may be replaced by some other experience prior to entry into a graduate program. Considerable concern was expressed about the residency, generally focused on the fact that most residencies are unstructured, and do not appear to have any clearly established goals or objectives. Furthermore, contact between the preceptor, or the person in charge of the resident, and the program faculty are often minimal. More liaison between these two groups may be needed so that the practitioner can have a greater idea of the content of the graduate program, and what should be expected of the individual resident.

A Model

As a result of the analysis of data collected in this project, a "flow model of health services management education and development" is presented in chapter VI. This model incorporated concepts of pre-career education, career opportunities, formal graduate education, and continuing education.

Major components of the model from a program content point of view were general societal information, "management" skills, an area of specialization such as financial management, planning, or chief executive officer development, and specific sub-system knowledge and information, such as would relate to the health care system. Specific courses were suggested with respect to the development of a generalized program for the training and education of chief executive officers.

This particular model should be useful to those who are involved in curriculum development as well as specific course development. It should also be useful to students, continuing education decision makers, and others who are interested in health care administration, and the education of managerial and administrative personnel.

ADDITIONAL AREAS FOR RESEARCH

Research often raises more questions that it answers. In the present research, a number of findings were developed as outlined in the previous section. However, further areas for additional research were noted as well as several questions. This section will review some of those areas and questions.

One major conclusion is that the role of the chief executive officer, especially in hospitals, is changing, in that more attention is directed toward outside contacts including planning agencies and community relations. For some administrators, these functions may require skills and abilities that they do not possess to the needed degree. The need for continuing education flows from this conclusion.

With respect to continuing education, several questions arise. Among these are: 1) Who should pay for continuing education? 2) Should universities and colleges be subsidized to assure the development and implementation of quality continuing education programs? 3) Who will serve the organization in the absence of the chief executive officer? 4) Should fellowships be provided for continuing education courses? 5) Is there a greater need for off-campus education at the baccalaureate level? 6) How can "managem[illegible]ills" be effectively taught? These and similar questions need to be resolved through research and perhaps some "natural experiments" whereby a sample of students move through different educational modes and the results of the educational experiences are analyzed.

A second general area for additional research involves the second level management personnel. A study similar to the one reported in this project should be launched in order to determine what, if any, unique educational characteristics these people have. Attention needs to be directed toward obstacles in educational and job performance improvement for these individuals and toward how the obstacles can be removed. In addition, attention needs to be directed towards determining whether or not their role is changing. Finally, an educational model involving both initial, graduate, and continuing education needs to be developed for this level, and promotional and other motivational systems whereby these individuals can receive necessary encouragement and recognition need to be clarified.

There is a need to develop methods of performance evaluation among administrative personnel. It is not clear what the goals of administrative personnel are and how they receive recognition. At one time, hospital administrators received general approbation if they successfully completed a building program. Now there are signs that cost effectiveness may be the basis for recognition but measurement is difficult. However, cost effectiveness has both short-run and long-run implications for the health care facility and its patients or clients. There is also the question of productivity motivation among employees and how this concept can best be developed.

The implications of the "Mr. Inside" versus "Mr. Outside" role of the chief executive need to be examined. This division is significant both in terms of the impact internally upon other administrative personnel as well as on external effectiveness. How does the hospital change, for example, when more attention is directed toward the community and preventive medicine? Will there be more mergers and affiliations, or combinations similar to those which took place in business in the 1960's? What will be the impact of such integration schemes in terms of administrative education and development? Will resultant organizations be more cost effective, and what will be the effect upon general patient care?

One final area of suggested research pertains to the sources of goal definitions. There were variations both within and between various groups of administrators. Do these variations arise due to institutional differences, or are they the result of differences in managerial style? Do these variations have an effect upon administration and patient care? Do these variations affect the career path of administrators? Should these goal concepts be included in educational programs?

These are several of the issues and questions arising from this particular project. The reader no doubt will note others as each person pursues the interests developed through education or actual job experience.

CONCLUDING COMMENTS

The need to integrate education and work roles, and the need for more contact between educators and administrators in different health care organizations and at different levels were two major needs emerging in this study. How one balances the preparation for the immediate first entry level job with the preparation for the long-run career potential of the individual is a critical issue not yet adequately addressed. Undoubtedly, there is a need for reinforcing the concept of life-long learning among health services administrators. Questions about who should pay for continuing education, how to conduct it, and who should choose those to attend need more consideration by all the parties to such health administration decisions.

It is clear that much more extensive dialog, more thought, more analysis, and perhaps more personnel exchange programs between health services administration education programs and the practicing professionals are needed to advance the development of education for the changing role of the health care administrator.

Expectations for the administrative role imply that the administrator must be primarily a strategist and an external contact person. The administrator will have to have great flexibility and gain more knowledge about total operations and interrelationships in the entire health care system. A major skill requirement will be that of community resource management. More emphasis will be given to management team activities, and the administrator will be more involved in coordinating and overseeing the activities of the divergent staff. Perhaps the major implication of the changing role of the health services administrator is the fact that administrative positions in health care organizations will evolve into some of the most challenging jobs in our society as well as some of the most vital ones.

CHAPTER II

A PROFILE OF THE HOSPITAL CHIEF EXECUTIVE OFFICER

Why is a profile of chief executive officers useful? What value is there to understanding the role and activities of chief executive officers? Such a role and activity profile is the first stage of better understanding the management function within the health care delivery system. Defining the task of the hospital chief executive can lead to further definition and better understanding of the characteristics of the many different administrative positions in the health delivery system. Job definition is also a necessary first step in assessing the performance of position occupants. By better understanding the characteristics of hospital chief executive positions, improving organizational and educational processes for selecting and preparing individuals to fill such positions becomes more feasible. Thus, job and role definitions have many potential implications for the health care delivery system, and for potential improvement in its administration.

SUMMARY OF FINDINGS

The profile of hospital chief executive officers developed in this chapter found:

1. The standards of the Joint Commission on Accreditation of Hospitals and the Guidelines for Bylaw Preparation of the American Hospital Association are a major influence upon the job descriptions of hospital chief executives.
2. Interpersonal relationships, motivation of subordinates and the initiation of change were presently the most time consuming and important roles, and their future importance was expected to remain high.

3. Interpersonal relationships, including community leadership, outside of the individual hospital, and decision-making regarding external negotiations will become more important in the future.

4. Determination of goals and objectives was consistently reported as presently the most time consuming and important activity and was expected to remain most important in the future.

5. Financial management was the second most time-consuming and important activity at present.

6. Government-related activities will become the second most important activity for chief executives in the future.

7. Operational management activities will decrease in importance in the future while externally-oriented activities will increase in future importance for chief executives.

8. Tasks involving policy issues, senior level personnel management, and external affairs are those which chief executives perform most frequently themselves.

9. Tasks involving basic level personnel management, the provision of patient care, and basic support tasks such as maintenance, safety, and purchasing programs are those which chief executives most consistently delegate.

10. Tasks related to financial management and standard operating procedures are sometimes delegated and sometimes performed directly by the chief executive officer.

BACKGROUND

A variety of strategies are typically employed in studies of the managerial job, including observation by the researcher, managers' self-recording of their activities and managerial estimates of what their time is spent on. Small groups of managers and executives are easily studied using the first two methods. Larger groups almost necessarily rely on the managerial estimation method. Campbell _et_. _al_. (1970) have noted the need to undertake substantially more studies aimed at measuring managerial job requirements.

In addition to the managerial job definition literature, there is a parallel stream of literature which views individuals as _role occupants_ within a network of _role relationships_. In this literature, an organizational system is a set of roles whose activities intersect, and the role occupants (or the role focal persons) are those individuals who perform the input, the transformation, and the output processing of the system (Katz and Kahn, 1966). Role, then, involves the behavior displayed by the actor or the incumbent in a position. Much as on the stage, the focal person or role occupant may seem to play multiple roles in any given situation. Managers especially may play multiple roles because of the diverse relationships which they encounter in carrying out their activities.

Mintzberg (1973; 1975) developed a framework of ten basic roles to describe the managerial job. His work thus represents an intersection of the managerial job definition literature and the role literature. The managerial role descriptions which he developed were based upon a study of five chief executives from five middle to large-sized American organizations. The role descriptions, drawn by Mintzberg from intensive observation of each chief executive during one week's time, are abstracted and summarized in Table II-1.

Finally, the traditional management literature emphasizes the broad categories of activities that a manager engages in, such as planning, organizing, and controlling. This literature defines the managerial job in a more global manner than the job definition literature by identifying broadly defined managerial functions and describing how these contribute to the total set of managerial behaviors. Ten managerial activities are identified and described in Table II-2.

One principal objective of this research contract was to "determine the nature of changes occurring in the present and future role of health care administration." The literatures on managerial job definition, role theory, and managerial functions were used as a basis for ascertaining the present role of health administration executives and for developing a forecast of their future role. This chapter develops a profile of hospital chief executive officers

Table II-1

MANAGERIAL ROLE DESCRIPTIONS
(Based on Mintzberg, 1973)

Interpersonal Roles

The Figurehead Role: The chief executive is a symbol required by the status of his office to carry out a variety of social, legal, and ceremonial duties in which he represents the organization.

The Leader Role: The chief executive has interpersonal relationships with his subordinates; as he hires, trains, and motivates them, he must essentially bring their needs in accord with those of the organization.

The Liaison Role: The chief executive has interpersonal relationships with people outside of his own organization and spends a considerable amount of time developing a network of high-status contacts in which information and favors are traded for mutual benefit and through which the chief executive exerts community leadership.

Informational Roles

The Monitor Role: The chief executive continually seeks and receives information about his organization in order to understand changing situations and his organization's environment.

The Disseminator Role: The chief executive shares some of the environmental information with his subordinates.

The Spokesman Role: The chief executive informs outsiders about the progress, problems, and activities of his organization.

Decisional Roles

The Entrepreneur Role: The chief executive takes the responsibility for bringing about changes in his organization, looking for problems and opportunities, and then initiating projects to deal with them.

The Disturbance Handler Role: The chief executive takes charge when his organization faces a major disturbance or crisis and deals with the resulting problems.

The Resource Allocator Role: The chief executive decides who will get what in his organization; he establishes priorities, designs his organization, and authorizes all important decisions.

The Negotiator Role: The chief executive takes charge whenever his organization must enter into crucial negotiations with other parties; his presence is required because he has the information and the authority to make the decisions that difficult negotiations require.

Table II-2

MANAGERIAL ACTIVITIES

Determination of Goals and Objectives: This consists primarily of activities dealing with policy-making committees and boards, where the subject matter concerns overall hospital policy.

Financial Management: This classification relates to the internal financial affairs of the hospital. It includes budgeting, both development and review.

Personnel Management: This category relates to the selection, evaluation, and motivation of employees. It includes wage and salary administration/determination.

Coordinating Department Operations: This category includes activities dealing with the internal functioning of any hospital department. Routine meetings with department heads would be one example, unless the subject matter clearly belonged in a different classification.

Program Review and Evaluation: This relates to the general functioning of the clinical services. It is concerned primarily with the evaluation and review of various projects and programs.

Planning-Facility and Program: This classification refers primarily to the activities involved in remodeling projects, space problems, and new facility construction as well as new services and programs. It does not include financing, personnel, etc.

Public and Community Activities: This classification concerns activities related to the development and maintenance of interaction with other health service-providing institutions/agencies, including shared service arrangements with other providers, coordination, etc.

Health Industry Activities: This classification refers to activities that are external to the hospital. It includes participation in hospital associations, professional societies, etc.

Government Related Activities: This activity is concerned with the legal problems of the hospital plus the activities in dealing with local, state, or federal agencies.

Educational Development: This category includes all teaching and lecturing responsibilities, plus personal continuing education.

since the most data were available on this position, and because the hospital appears to be evolving into a central position in the entire health care delivery system. However, data on the chief executive's role in other institutional settings are summarized in later chapters of this report.

A number of data sources were utilized in preparing this profile of the hospital chief executive officer. Included among these are:

1. The Accreditation Manual for Hospitals (Joint Commission on Accreditation of Hospitals, 1973);
2. The Guide for Preparation of Constitution and Bylaws for General Hospitals (American Hospital Association, 1973);
3. Job Descriptions provided by hospital administrators as part of their response to the project questionnaire.
4. Selected questions related to managerial functions, roles, and tasks from the project questionnaire.

ROLE PRESCRIPTIONS

The role theory literature proposes that, in addition to role occupants, each system of role relationships encompasses individuals who are called role senders. Role senders evaluate the behavior of role occupants, develop expectations about their role, and attempt to influence the role behavior of the role occupants. Standards-setting and accrediting agencies may be especially potent role senders as may nationally recognized professional associations. For hospital chief executive role occupants, the Joint Commission on Accreditation of Hospitals (JCAH) and the American Hospital Association (AHA) are, respectively, an accrediting agency and a professional organization with role sender characteristics.

Both the AHA and the JCAH publish statements regarding the role of the hospital chief executive officer which amount to role prescriptions or statements of expectations of the role the chief executive should play. Hospitals are expected to meet the accreditation requirements of the JCAH. The AHA essentially provides information to its member hospitals in order to enable them to conform to the accreditation requirements. Table II-3 summarizes selected parts of the JCAH accreditation standards; Table II-4 summarizes the AHA statements about the hospital chief executive officer suggested for inclusion in hospital bylaws. Table II-3 includes four standards related to the chief executive officer; the complete interpretation of Standard IV is also included since it details the educational and experience qualifications of the chief executive officer, the establishment of guidelines for relationships, the policy implementation role of the chief executive, his duty to organize the administrative functions of the hospital, and the reporting requirements incumbent upon him.

Table II-3

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

SUMMARY OF SELECTED STANDARDS

GOVERNING BOARD AND MANAGEMENT

Standard IV--The governing body shall appoint a chief executive officer whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body.

> The chief executive officer should be qualified by education and experience appropriate to the proper discharge of his responsibilities. It is desirable that the chief executive officer have at least a baccalaureate and a minimum of three years' experience in a responsible administrative position in a hospital, or in the health care field, or have completed formal education in a graduate program in hospital administration approved by the Accrediting Commission on Graduate Education for Hospital Administration. The chief executive officer shall designate an individual to act for him in his absence, in order to provide the hospital with administrative direction at all times.

The governing body must establish guidelines for relationships among itself, the chief executive officer, the medical staff and the community. The chief executive officer is continuously responsible for the management of the hospital, commensurate with the authority conferred on him by the governing body and consonant with its expressed aims and policies. The governing body shall hold him responsible for the application and implementation of established policies in the operation of the hospital, and for providing liaison among the governing body, the medical staff and the departments of the hospital. He should attend all meetings of the governing body and appropriate meetings of the medical staff.

The chief executive officer should organize the administrative functions of the hospital, delegate duties and establish formal means of accountability on the part of subordinates. He should establish such hospital departments as are indicated, provide for departmental and interdepartmental meetings and attend, or be represented at, such meetings. To maintain effective liaison between the medical staff and departments of the hospital, the chief executive officer should name hospital departmental representatives to medical staff committees, where appropriate and when requested by the medical staff.

The chief executive officer should make or send reports to the governing body and to the medical staff on the overall activities of the hospital, as well as on appropriate federal, state and local developments that affect health care in the hospital.

Standard V--The governing body, through the chief executive officer, shall provide appropriate physical resources and personnel required to meet the needs of the patients, and shall participate in planning to meet the health needs of the community.

Standard VI--The governing body, through its chief executive officer, shall take all reasonable steps to conform to all applicable federal, state and local laws and regulations, including those relating to licensure, fire inspection and other safety measures.

Standard VII--The governing body, through its chief executive officer, shall provide for the control and use of the physical and financial resources of the hospital.

Source: Accreditation Manual for Hospitals (Joint Commission on Accreditation of Hospitals, 1973).

Table II-4

AMERICAN HOSPITAL ASSOCIATION

SUGGESTED BYLAW ARTICLE: ADMINISTRATION

Article VI. Administration

Section 1. The governing board shall select and appoint a competent chief executive officer who shall be its representative in the management of the hospital. This executive officer shall be given the necessary authority and responsibility to operate the hospital in all its activities and departments, subject only to such policies as may be issued by the governing board or by any of its committees to which it has delegated power for such action. He shall act as the duly authorized representative of the governing board in all matters in which the governing board has not formally designated some other person to so act.

Section 2. The authority and responsibility of the chief executive officer shall include:

a. Carrying out all policies established by the governing board and advising on the formation of these policies.

b. Developing and submitting to the governing board for approval a plan of organization for the conduct of hospital operation and recommended changes when necessary.

c. Preparing an annual budget showing the expected revenue and expenditures as required by the governing board or its finance or executive committees.

d. Selecting, employing, controlling, and discharging employees and developing and maintaining personnel policies and practices for the hospital.

e. Maintaining physical properties in a good and safe state of repair and operating condition.

f. Supervising business affairs to ensure that funds are collected and expended to the best possible advantage.

g. Working continually with other health care professionals to the end that high-quality care may be rendered to the patients at all times.

h. Presenting to the governing board, or its authorized committee, periodic reports reflecting the professional services and financial activities of the hospital and such special reports as may be required by the governing board.

i. Attending all meetings of the governing board and service on committees thereof.

j. Serving as the liaison and channel of communications between the governing board and any of its committees and the medical staff and assisting the medical staff with its organization and medico-administrative problems and responsibilities.

k. Preparing a plan for the achievement of the hospital's specific objectives and periodically reviewing and evaluating that plan.

l. Representing the hospital in its relationships with other health agencies.

m. Performing other duties that may be necessary or in the best interest of the hospital.

Source: Guide for Preparation of Constitution and Bylaws for General Hospitals (American Hospital Association, 1973).

Tables II-3 and II-4 enumerate a number of roles, tasks, and activities which hospital chief executive officers are expected to engage in. Such statements or prescriptions of role and job expectations from knowledgeable and respected role senders should have a substantial impact upon individual chief executives in their personal role definition. Table II-3 emphasizes the overall management responsibility of the chief executive officer subject to the governing body's control and direction. He is responsible for policy implementation, internal liaison and representation, the organization and delegation of duties, and the accountability of the entire hospital staff as well as for reporting on internal and external developments affecting the hospital. Standard V indicates that the chief executive is responsible for personnel policies and practices supporting sound patient care, including accurate records of personnel and their health status. In addition, planning and coordination with other community health care services and educational development for staff and community are responsibilities ultimately assigned to the chief executive. Standard VI requires responsiveness to regulatory agencies, and Standard VII emphasizes fiscal management duties, including internal controls such as an accounting system, a departmental budget program, and a procedure manual; also required are a defined risk management program, purchasing policies, and an annual audit.

Table II-4 essentially provides a restatement of the JCAH standards contained in Table II-3, but in such a way that they can be readily incorporated into a hospital's bylaws. Again, statements about qualifications of the chief executive, his management authority subject to the governing body, and his representational role all appear. Specific duties regarding the policy, organizational, fiscal, personnel, reporting, liaison, community, and developmental activities of the chief executive are then enumerated.

It is clear that both the Joint Commission and the AHA statements are designed toward role definition for the hospital chief executive officer. Both statements describe the internal management and external representation aspects of the chief executive's job; yet, there is a tendency in both statements to emphasize the operational and internal aspects of the chief executive job. In terms of the task enumeration from the AHA statement, only two statements (g and l) focus upon the external aspects of the chief executive's job. Much the same is true of the JCAH standards and their interpretation--internal operational management of the hospital appears central to the chief executive officer's position according to these role prescriptions.

CHIEF EXECUTIVE OFFICERS' JOB DESCRIPTIONS

One part of the research project involved data collection from a national sample of health care institution chief executive officers. Respondents to the survey questionnaire were asked to provide job descriptions if one existed for their position. Eighty-three per cent of the hospital chief executives reported that a job description existed for their position; however, only nineteen per cent provided one with their questionnaire response. Nevertheless, comparisons of the bed size distribution of respondents providing job descriptions with national hospital size data from the Guide to the Health Care Field of the American Hospital Association (1976) indicate that the distribution of respondents is not significantly different from that of the population.

The job descriptions were analyzed using a content analysis methodology. A sample of the descriptions was first examined to establish a tentative list of categories. It was in this stage that the similarity of the job descriptions to the JCAH standards and the AHA Guidelines was first noted. Once the tentative categories were established, all the job descriptions were read and classified with tallies made of repeated statements. Additional statements were added to the tentative list of categories as needed. The tally was maintained and the descriptive statements were arranged in rank order by frequency of mention.

Substantial numbers of the job descriptions were based upon the AHA Guidelines with many respondents sending an excerpt from their institution's bylaws; about 10% of these bylaw--job descriptions quoted the AHA guidelines directly. The balance added a variety of statements to the guidelines and some of the bylaws appeared to reflect particular circumstances of an individual hospital. Other job descriptions were received which, while separate documents from the hospital bylaws, clearly were based upon the AHA suggestions and the JCAH standards.

Table II-5 enumerates the great variety of job description statements. Examination of the table provides a broad mosaic of the types of duties, responsibilities, and activities that hospital chief executives are expected to engage in within various institutions. The items are grouped into a number of categories derived from the role prescription sources discussed in the previous section.

The breadth and depth required of hospital chief executives is clearly reflected in these major categories. They are responsible for policies and procedures, the organization's administrative structure, personnel management, planning, financial management, reporting to the board, relations with the medical staff, overseeing patient care, maintaining the physical plant, caring for legal matters, and maintaining good community relations. How these varied activities are sorted out into workable daily routines is a critical question.

Perhaps the single most interesting conclusion derived from Table II-5 is the substantial impact of the JCAH and AHA role prescriptions upon the individual chief executive's job description. These two professional sources' role expectations find their way into most of the job descriptions. To the extent that a job description shapes the role occupants' perception of his job and his subsequent behavior, then these professional sources appear to have a substantial impact upon defining the role of the hospital chief executive officer. The local amplifications of the standards are interesting but not nearly as significant as the substantial acceptance of the two groups' national role prescriptions.

Table II-5

HOSPITAL CHIEF EXECUTIVE RESPONDENTS

SUMMARY OF JOB DESCRIPTION STATEMENTS

Policies and Procedures

1. Responsible for the application and implementation of policies established by the board;
2. Advise board on formation of hospital policies;
3. Interpret policies to employees;
4. Establish administrative policies, rules, and regulations;
5. Provide policy evaluation reports to board;
6. Develop and maintain a policy manual.

Administrative Authority and Organization

1. CEO continuously responsible for management of the hospital consistent with his authority determined by the board and board policies;
2. Responsible for organization of administrative functions, delegation of duties, and establishing formal means of accountability of subordinates;
3. Establish necessary hospital departments and provide for departmental and interdepartmental meetings and attend or be represented at such meetings;
4. Develop and submit to board a plan of organization for the conduct of hospital operations;

5. Recommend needed organizational changes to the board;
6. Establish evaluation systems for hospital operations;
7. Provide safeguards for the proper use of facilities and the health and welfare of employees;
8. Supervise day-to-day activities;
9. Maintain license of institution;
10. Develop an administrative committee;
11. Coordinate activities of all hospital departments designated by the board;
12. Establish a risk management program for the hospital;
13. Provide resources to meet the emotional and spiritual needs of patients.

Personnel Management

1. Personnel policies:
    a. The board, through the chief executive officer, should ensure that personnel policies adequately support sound patient care;
    b. Personnel policies should be available to all employees and discussed with them;
    c. Employees should be notified of any changes in policies.
2. Accurate and complete personnel records should be maintained for each employee;
3. The chief executive officer should designate an individual to review personnel records at least annually:
    a. Records should contain current and background information sufficient to justify initial and continued employment;
    b. Current information relative to work performance evaluations should be contained in records;
    c. Records of preemployment and continued health examinations should be included.

4. Orientation and inservice training programs should be provided for hospital personnel by the board;
5. Develop and review a wage and salary program;
6. Responsible for selecting, employing, controlling, and discharging employees and developing and maintaining personnel policies and practices for the hospital;
7. Develop and maintain job descriptions;
8. Provide for the health and safety of employees.

Planning

1. Develop a plan of action for the hospital to be reviewed and approved by the board of directors;
2. Initiate adequate comprehensive planning;
3. Provide information on changing economic, social, and legal forces;
4. Provide information on changes in medical technical advances;
5. Prepare a plan for the achievement of the hospital's specific objectives and periodically review and evaluate that plan.

Financial Management

1. Responsible for the preparation of a budget with appropriate administrative staff as required by the governing board;
2. Supervise business affairs to ensure that funds are collected and expended to the best possible advantage;
3. Responsible for implementing board policies in effective utilization of financial resources of the hospital;
4. If assigned by the governing board is responsible for maintaining an accounting system reflecting fiscal experience;
5. If assigned by the board develops written policies and procedures for the control of accounts receivable, handling of cash, for credit arrangements, and discounts;
6. Provides a current written schedule of rates and charges;

7. Informs board of contracts entered into;

8. Reviews and signs board approved grants;

9. Is responsible for purchasing of equipment and supplies, seeking board approval when required;

10. Review reports of independent audits of financial operations.

Reporting

1. Prepare reports for board and medical staff on the overall activities of the hospital;

2. Prepare reports for board and medical staff on appropriate federal, state, and local developments that affect health care in the hospital;

3. Prepare special reports requested by the board;

4. Prepare periodic reports to board reflecting professional services and financial activities;

5. Provide information on the condition of the hospital;

6. Is responsible for providing appropriate reports for external agencies;

7. Review and take necessary action to comply with reports from inspection or licensing agencies and report status to the board.

Medical Staff Relations

1. Serves as a liaison and channel of communications between the governing board and any of its committees and the medical staff;

2. Assists the medical staff with its organization and medico-administrative problems and responsibilities;

3. Is an ex-officio member of all medical meetings;

4. Reviews and transmits recommendations for appointment to the medical staff to the board of trustees;

5. Names departmental representatives to medical staff committees where appropriate and when requested by medical staff.

Patient Care

1. Works continually with other health care professionals to the end that high-quality care may be rendered to all patients at all times;

2. Assures treatment of patients with dignity, courtesy, and respect.

Meetings

1. Attend all meetings of the governing board;

2. Attend appropriate meetings of the medical staff;

3. Attend meetings of board committees as appropriate;

4. Attend meetings of board established committee to provide a formal means of medico-administrative liaison among the governing board, the administration, and the medical staff.

Physical Plant

1. Maintains physical properties in a good and safe state of repair and operating condition;

2. Recommends to the board and contracts for new construction when approved by the board of trustees.

Legal Matters

1. Refers legal matters to hospital counsel and keeps board informed;

2. Negotiates contracts for regular hospital services.

Community Relations

1. Represents the hospital in its relationships with other health agencies;

2. Develops good public relations;

3. Responsible for liaison between hospital and community;

4. Represents hospital to other health agencies;

5. The hospital should assist the community in meeting its responsibility to provide adequate health personnel; the board should foster the education function of the hospital;

6. Participate in local, state, and national professional associations;

7. Participate in local, state, and national health planning agency activity.

Other

1. Perform other duties that may be necessary or in the best interest of the hospital;

2. Work with auxiliary and volunteer groups;

3. Assist in fostering hospital research.

SURVEY OF HEALTH SERVICES ADMINISTRATORS

The job description information reviewed in the previous section was collected as one part of a survey of health services administrators, conducted with a mailed questionnaire distributed to a national sample of hospital, long-term-care facility, clinic, and HMO administrators. The response rate for each group was approximately forty per cent. Data on non-hospital administrators are discussed in subsequent chapters as are most of the data derived from the questionnaire. Only those sections which provided role delineation information are discussed here.

The hospital administrator respondents fall within the known bounds of the distribution of all hospitals within the United States, based upon comparisons of data for bed-size, census, and total employees with data from the Guide to the Health Care Field of the American Hospital Association (1976). Three forms of the questionnaire were distributed to Hospital Administrators. These three forms had different pages 4 and 5, but all other questions were identical across forms.

The three forms asked questions respectively about the managerial roles, managerial activities, and managerial task divisions within the institution. The respondents to each form appear to be representataive of the known distribution of hospitals in the United States. (See Appendix A for more detail.)

The managerial role descriptions form of the questionnaire contained one page of managerial role descriptions based upon Mintzberg (1973), and shown in Table II-1 (p. 24). Respondents were asked three questions about these managerial role descriptions which required the administrator to indicate how much of his time each role consumed; how important each role was in attaining his organization's goals; and what he anticipated the importance of each role to be in the future (three to five years). Administrators were given a forced distribution in which to place the ten managerial roles. The distribution and the directions requested them to select the least time-consuming and the most time-consuming roles, and to place them in two boxes so marked. They were then instructed to select the next two least time-consuming roles and the next two most time-consuming roles, and to place them in the appropriate boxes. The remaining four roles were to be placed in a box marked average. The directions for the importance and anticipated importance questions were parallel.

The managerial activities form of the questionnaire contained one page of statements of managerial activities or functions, shown in Table II-2 (page 25). Respondents were asked three questions about these managerial activities related to their time consumed, importance, and anticipated importance. The three questions and the forced distribution response format were exactly parallel to those on the managerial role descriptions form described above.

The questionnaire form seeking information on task activity divisions within the institutions provided a list of 47 administrative tasks derived from a number of job-task activity checklists. The administrators were asked to respond to these 47 tasks by checking one of four columns which were headed by terms designed to assess the personal involvement of the administrator in accomplishing the task. The column headings were defined as: 1) Performed directly, a primary duty of mine; 2) Accomplished indirectly, a responsibility of mine achieved by delegating it to others; 3) Performed by others, not a direct responsibility of mine; 4) Not performed in the organization.

The questionnaire distributed to these hospital executives then provided information regarding managerial roles, managerial activities/functions, and those task activities which are performed directly by the chief executive position incumbent or by others in the organization. In addition, for the managerial roles and activities, information was available on the time consumed, importance, and the anticipated importance of the roles and activities as they were viewed by the hospital chief executives. The questionnaire data essentially provide self-report descriptions by the chief executives of their managerial jobs.

MANAGERIAL ROLE DESCRIPTIONS

Table II-6 presents the mean scores and rankings for the hospital administrators' ratings of time consumed, importance, and anticipated importance of the managerial roles. The roles are arranged in rank order, based on the time consumed column's mean scores. Responses in the average category were coded as a "3" while most time consumed (importance, anticipated importance) was coded as a "5" and least time-consumed (importance, anticipated importance) was coded as a "1." Thus, a mean score above 3 indicates above-average time consumed, importance, or anticipated importance, while a mean score below 3 means that the role was considered to be below average.

TABLE II-6

MANAGERIAL ROLE DESCRIPTIONS*

HOSPITAL ADMINISTRATORS

	TIME CONSUMED		IMPORTANCE		ANTICIPATED IMPORTANCE	
ROLE	MEAN	RANK	MEAN	RANK	MEAN	RANK
The Leader	3.960	1	3.942	2	3.597	2
The Entrepreneur	3.780	2	3.951	1	3.689	1
The Monitor	3.455	3	3.331	3	3.156	6
The Resource Allocator	3.331	4	3.275	4	3.189	5
The Liaison	2.845	5	3.137	5	3.453	3
The Negotiator	2.774	6	2.900	6	3.240	4
The Disseminator	2.692	7	2.525	9	2.478	9
The Disturbance Handler	2.674	8	2.610	8	2.587	8
The Spokesman	2.631	9	2.675	7	2.921	7
The Figurehead	1.869	10	1.751	10	1.809	10

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*Responses were scaled: 1 = Least (Time Consumed, Importance, Anticipated Importance); 2 = Below Average (Time Consumed, Importance, Anticipated Importance); 3 = Average (Time Consumed, Importance, Anticipated Importance); 4 = Above Average (Time Consumed, Importance, Anticipated Importance); and 5 = Most (Time Consumed, Importance, Anticipated Importance).

The Leader and the Entrepreneur roles rank first or second in all three columns. The Leader role emphasizes the importance of interpersonal relationships and of motivation of subordinates while the Entrepreneur role focuses upon the change-initiation aspects of the chief executive job. The Leader and Entrepreneur roles are, respectively, interpersonal and decisional roles as Mintzberg's grouping in Table II-1 shows. The third ranked role in the time consumed and importance column is the Monitor role, from the informational roles group. This third ranked present role in some ways is similar to the Entrepreneur role in its definition, but its focus is more upon understanding situations facing the organization rather than upon initiating action to deal with those situations. Taken together, these three top ranked roles in both time consumed and importance suggest that the chief executive respondents view themselves as central figures in their organizations' information networks, with key responsibilities in the areas of initiating change and motivating their subordinates.

The fourth, fifth, and sixth ranked roles in the Time Consumed and Importance columns include the Resource Allocator, the Liaison, and the Negotiator roles. The Resource Allocator role scored above average in time consumed, while both the Resource Allocator and the Liaison roles were above average in importance. Decisional and interpersonal roles thus represent five of the six most time consuming and important roles at present for the chief executives. Finally, the lowest ranked roles included two informational roles--Disseminator and Spokesman, one decisional role--Disturbance-Handler, and one interpersonal role--Figurehead.

While the self-reported distribution of managerial roles at present emphasizes the internal role of the chief executive in his Leader, Entrepreneur, and Monitor roles, the future appears somewhat different. The mean scores of four roles increase in the anticipated importance column as compared with the importance mean score: Liaison, Negotiator, Spokesman, and Figurehead roles. All four of these roles are externally oriented and involve the chief executive's contacts and dealings with individuals outside of his organization.

The Entrepreneur and Leader roles decrease in their mean scores but are still the first two ranked roles in anticipated importance, suggesting that the respondents do not necessarily see themselves giving up these roles to any great extent--even though they are taking on more extramural contacts. The Liaison and Negotiator roles ranked third and fourth in anticipated importance. Thus, the four roles with the highest anticipated importance include two decisional roles and two interpersonal roles. No shifts occur in the rankings of the four lowest scoring roles from the importance to the anticipated importance columns, although as noted the mean scores of the Spokesman and Figurehead roles do increase.

Thus at present and in the future, internal management roles involving motivation and change are most highly rated. The chief executive is and will remain concerned about certain vital aspects of his institution as an inside-man. However it is clearly true that the role of the chief executive as outside-man is on the increase. Four different externally oriented roles increase in their anticipated importance: Liaison, Negotiator, Spokesman, Figurehead. The implication is that the chief executive will add new externally oriented functions without giving up present ones to any great extent. This change can only make the role more challenging.

MANAGERIAL ACTIVITIES

Table II-7 presents the mean scores and rankings for the hospital administrators' ratings of time consumed, importance, and anticipated importance of the managerial activities. The activities are arranged in rank order, based on the time consumed column's mean scores. Responses were scored in the same manner as the managerial role descriptions questions with a value of 3 assigned to the average category, 1 to the least, and 5 to the most time consumed, importance, and anticipated importance category.

Determination of goals and objectives and financial management are the two most time-consuming and most important activities with their mean importance scores somewhat higher than their mean time-consumed scores. These two most important activities clearly suggest that the respondents view broad policy determination and financial management as their principal organizational activities. Third and fourth ranked are another operational activity, coordinating department operations, and another policy activity, planning for facility and program. These activities reverse order from the time consumed to the importance column, largely because departmental coordination is reported to be more time-consuming than it is important for overall goal attainment. The fifth and sixth ranks also contain an operational activity, personnel management, and a policy activity, program review and evaluation. Again, a reversal of the two ranks occurs in comparing column one with column two because the operational activity is rated as slightly lower in importance than in time consumed.

All four of the managerial activities which appear to have an external orientation, government-related activities, public and community activities, health industry activities, and educational development, are the four lowest ranked activities at present both in terms of the time consumed and their importance.

TABLE II-7

MANAGERIAL ACTIVITIES*

HOSPITAL ADMINISTRATORS

ACTIVITY	TIME CONSUMED		IMPORTANCE		ANTICIPATED IMPORTANCE	
	MEAN	RANK	MEAN	RANK	MEAN	RANK
Determination of Goals and Objectives	3.703	1	4.066	1	3.695	1
Financial Management	3.556	2	3.686	2	3.546	3
Coordinating Department Operations	3.511	3	3.224	4	2.825	7
Planning--Facility and Program	3.324	4	3.333	3	3.162	4
Personnel Management	3.014	5	2.996	6	2.824	8
Program Review and Evaluation	2.935	6	3.070	5	3.019	5
Government Related Activities	2.864	7	2.821	7	3.663	2
Public and Community Activities	2.819	8	2.794	8	3.000	6
Health Industry Activities	2.542	9	2.242	9	2.500	9
Educational Development	1.784	10	1.829	10	1.951	10

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*Responses were scaled: 1 = Least (Time Consumed, Importance, Anticipated Importance); 2 = Below Average (Time Consumed, Importance, Anticipated Importance); 3 = Average (Time Consumed, Importance, Anticipated Importance); 4 = Above Average (Time Consumed, Importance, Anticipated Importance); and 5 = Most (Time Consumed, Importance, Anticipated Importance).

This ranking emphasizes quite clearly that the activities of hospital chief executives at present are focused principally upon the internal operations of their institutions with a fairly even division between policy activities and direct operational activities. Outside governmental, community, and professional activities presently have a relatively low rank, both in estimates of time spent in these activities and in their rated importance.

The ratings of anticipated future importance of the activities show some definite changes. All four outside activities increase in their mean scores of anticipated importance when compared to the present importance means. In addition, while the six policy and operational activities all show a decreased mean score, coordinating departmental operations and personnel management fall in the ranking to become seventh and eighth in anticipated importance, clearly suggesting a de-emphasis by the chief executive on "nuts and bolts" operational management. Government-related activities increased substantially in anticipated importance from their present importance, ranking second in the future.

Determination of goals and objectives remains first ranked while financial management moves down slightly to rank third after government-related activities. Thus, in terms of the future anticipated importance of these managerial activities, policy determination, governmental relations, and financial management are distinctively the three major activities the chief executives rated as having the most future importance. It may well be that these three are so inextricably interwoven that what the results really indicate are the increasing importance of developing forward looking policy for the hospital, the subsequent need to attain the funds to support that policy, and the official sanctions to implement it.

Again these data indicate that internal management activities are rated highly important at present and in the future while external involvement is rated low at present. The anticipations of increasing external involvement are present in the managerial activities data as in the roles data. The

. chief executive of the future will be actively involved both in internal and external affairs with almost equal weight given to determining goals and objectives, financial management, and governmental relations. This pattern of activities reflects an increasingly complex role.

MANAGERIAL TASK ACTIVITIES

Table II-8 presents data from the managerial task activities form of the questionnaire. The two major columns summarize those tasks which the administrators most frequently perform themselves and those tasks which they reported were delegated to others in their organizations, obtained by combining response categories 2 and 3 from the questionnaire. The ranks of the tasks in each column are also shown. The fourth response category, "not performed by personnel in the organization," elicited more than a five per cent response for only two statements, "Negotiate labor union contracts," 55.13%; and "write articles for professional journals of benefit to other administrators," 43.64%.

Reading down the left hand column provides an indication of the activities which the hospital chief executives consider as requiring their own performance. Alternately, reading up the table from the bottom of the right hand column provides a relatively clear statement of those tasks which the chief executives do not consider to be their own but which they regularly delegate.

Reviewing Table II-8, for the ten tasks reported as being performed directly by 75% or more of the chief executives, there appear to be three major types of activities involved: policy matters, internal management, especially of senior level personnel, and external affairs. Advising the board of trustees and long range planning relate to policy. Appointing administrative personnel and department heads, and approving their promotions are definitely internal management tasks as is approving the purchase of expensive equipment. Assisting the medical staff, representing the organization, and keeping informed of legal changes relate to external affairs and agents. Thus, the reported task activities

TABLE II-8

DISTRIBUTION OF TASKS

HOSPITAL ADMINISTRATORS

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Advise the board of trustees on matters requiring policy formulation	93.45	1	4.76	47
Appoint administrative personnel	91.23	2	8.19	46
Assist medical staff with its organizational & medical-administrative problems and responsibilities	84.52	3	14.88	45
Represent organization on commissions, agencies, or at hearings	82.84	4	16.57	43
Represent the organization in its relationships to other health agencies	77.65	5	22.35	40
Develop a long range planning program for the organization	77.51	6	20.12	42
Keep informed of legal changes affecting the organization	76.92	7	23.08	38
Approve purchases of expensive equipment	76.47	8	22.94	39
Appoint department heads	76.02	9	23.39	37

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Approve promotions & transfers of department heads	75.15	10	24.85	36
Recommend to the board the rates to be charged for services	73.65	11	22.16	41
Allocate organizational resources to achieve organizational goals	68.86	12	29.94	34
Evaluate managerial performance	67.65	13	32.35	33
Communicate health care needs to persons external to the organization	65.66	14	33.13	32
Interpret policies, procedures, & regulations	62.13	15	37.87	30
Meet regulatory & accreditation requirements	62.05	16	36.75	31
Prepare administrative reports	55.88	17	44.12	29
Interpret changes in rules & regulations (governmental policies, for example) to organizational employees	46.20	18	53.80	27
Negotiate financial agreements (insurance and facilities)	45.88	19	53.53	28
Review and revise budget allocations	45.83	20	54.17	26

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Establish procedures for preparing and submitting reports	44.12	21	55.88	25
Formulate wage & salary pay plans	40.00	22.5	57.06	24
Write articles for professional journals of benefit to other administrators	40.00	22.5	16.36	44
Analyze expenditures	37.87	24	61.54	22
Search the organization and its environment for more efficient operations	37.72	25	61.68	21
Formulate Personnel Policies	34.94	26	60.24	23
Plan and determine manpower requirements	34.12	27	65.88	19
Solve cash flow problems	32.93	28	65.27	20
Enforce administrative policies and operating procedures	32.74	29	67.26	18
Plan administrative office practices and procedures	27.06	30	72.94	16

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Negotiate reimbursement rates with third party payers	26.19	31	69.64	17
Conduct studies of financial performance and recommend changes	26.04	32	73.37	15
Investigate patient/resident complaints	25.44	33	74.56	14
Resolve employee complaints and grievances	23.21	34	76.19	13
Prepare operations budget	20.71	35	79.29	12
Evaluate training programs	19.76	36	80.24	11
Coordinate personnel programs	19.30	37	80.70	10
Negotiate labor union contracts	17.31	38	27.56	35
Plan and determine health care quality standards	15.06	39	84.94	9
Develop personnel recruiting methods	14.62	40	85.38	8

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Organize health care services	8.93	41	90.48	7
Contract for purchase and delivery of supplies and services	7.74	42	92.26	6
Formulate patient care policies	7.19	43	92.81	5
Coordinate safety programs	5.99	44	94.01	4
Coordinate maintenance and repair activities	4.73	45	95.27	2
Direct and coordinate activities of nursing services	4.14	46	94.67	3
Direct Personnel Training Programs	2.35	47	97.65	1

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[1] This column shows the percentage of respondents who answered the question by checking the column headed "Performed Directly." The column heading was further explained by the statement, "This activity is a primary duty of mine and is usually performed directly by me."

[2] This column shows the combined percentage of respondents who answered the questions by checking either of the two columns headed "Accomplished Indirectly" or "Performed by Others." These column headings were further explained by the statements, "This activity is a responsibility of mine but is usually accomplished indirectly by my delegating it to others," and "This activity is not a direct responsibility of mine but is performed by other individuals in the organization."

A fourth column was headed "Not Performed" and explained that "This activity is not performed by personnel in the organization."

suggest that the chief executive is policy-maker, manager of the personnel, and outside contact person for the hospital.

Those tasks least often performed directly by the chief executive provide an impression of what the second and third level hospital administrative personnel may find as their principal task activities. The delegation may potentially be to even lower levels in the organization, thus these findings represent only an impression rather than a definitive picture of the second and third level staff's task activities.

Of the fourteen tasks least frequently performed directly by chief executives (ranks 34--47, performed by less than 25%), five of the tasks relate to the personnel function and four to patient care. Dealing with employee complaints, evaluating training programs, coordinating personnel programs, developing recruiting methods and directing training programs all relate to the organizations' human resources management activities at basic levels. (Negotiating labor union contracts would fit here also but it is not generally done in these organizations). Planning health care quality standards, organizing health care services, formulating patient care policies, and coordinating nursing services relate directly to the provision of patient care. Other delegated tasks relate to safety program coordination, maintenance and repair activities, purchasing, and preparation of the operations budget.

Sorting out the tasks performed by more than 75% of the chief executives or by less than 25% of them still leaves 23 of the 47 tasks in the middle range of 25 to 75 per cent. Most of the basic financial management tasks fall in this category as do some other tasks related to standard operating procedures. The preferences of the chief executive and his staff, the size of the institution, and the capabilities of those involved presumably determine the extent of delegation which exists for these tasks in the middle range.

Considering the managerial roles, managerial activities, and managerial tasks data together provides an interesting picture of the hospital chief executive. Policy making, determination of goals and objectives, and the entrepreneur role all emphasize the major concern of chief executives with the question of where their institution is going. They are the long range planners and the strategists who influence the course of their institution through leadership roles, senior level personnel management, and financial management. Furthermore, the executives are the representatives of their institutions and will become even more concerned with representation before governmental agencies in the future.

The future role of the hospital chief executive will be especially challenging. New roles, tasks, and activities will be added on to those already present without really surrendering very many of the present ones. The representational roles involving external groups, and being a Spokesman and Liaison become more important and perhaps may force the chief executive to stretch and apportion his time even more carefully. There must be realistic limits on how much any executive can do. The challenge will be in recognizing those limits and developing plans and strategies to achieve goals within them if the hospital chief executive job is to be a reasonable and manageable one.

SUMMARY

The objective of this chapter was to provide a profile of the job of the hospital administrator. This particular position was chosen because it provides the prototype of administrative positions in other organizations such as long term care facilities, clinics, health maintenance organizations, and other health care institutions. Several sources of data were utilized in order to describe the job of the hospital administrator.

Of significance is the impact of the Joint Commission on Accreditation of Hospitals. The influence of the standards set forth by this agency as well as the American Hospital Association's suggested Guidelines for hospital bylaws was reflected in an examination of the job descriptions submitted to the project by hospital administrators. Insofar as job descriptions prescribe the job of the incumbent, the influence of these organizations is clearly present in defining the position of the chief executive officer.

Chief executive officers perceived the roles of Leader, Entrepreneur, Monitor, and Resource Allocator to be most time consuming and important for them. However, they were of the opinion that the roles of Liaison and Negotiator would be of more importance in the future.

Among the managerial activities performed by chief executive officers, the determination of goals and objectives, financial management, coordinating department operations, and planning facilities and programs were perceived to be most time consuming and important at the present time. In the future, however, government related activities were thought to be more important and coordinating department operations was expected to be a much less important activity.

Specific tasks most frequently performed by the respondents included tasks related to policy issues, senior level personnel management and external affairs. Tasks most frequently delegated to others included those related to basic personnel management activities and to patient care services as well as safety, maintenance, and purchasing.

This summary of roles, activities and duties reflects the chief executive officer position of the hospital administrator. As such, his role is moving toward more emphasis on policy making, forward planning, external relationships, and community activities. This role may force a shift away from internal commitments which will be delegated to staff (administrative skill exercises such as implementing procedures, coordinating line activities, etc.). This change in role must be reflected in changing duties away from routine administrative operations and toward more policy determination issues.

Finally, a complete delineation of possible role and performance activities was ascertained from an examination of the job descriptions submitted. These descriptions suggest a potentially wide range of roles and duties. However, the board of trustees will need to exercise its authority in delineating the specific role and duties in an individual hospital. Since a person tends to develop a role, it is probably also wise to suggest that the role and duties be developed in consultation with the chief executive if the position is not carefully and specifically delineated in terms of objectives at the initial appointment of the chief executive officer.

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CHAPTER III

THE FIELD OF HEALTH SERVICES ADMINISTRATION: HISTORICAL PERSPECTIVE

In mankind's continuing struggle to control his environment and improve the quality of life, any itemized list of victories and improvements would be endless. Yet the development of a modern health care system is one major improvement which has had a direct effect on the quality of living conditions and even on man's survival. The extensive scope of this health care system is especially evident in the United States. In 1973 in the United States, there were 7,183 hospitals with 1.53 million beds and some 31.7 million in-patient admissions. In 1971, there were 316,545 doctors in the United States, and 12,871 nursing homes with 917,707 beds and 824,038 residents. In 1973, 377,020 patients were admitted to state and county mental hospitals. The principal measurable product of this extensive health care system is reflected in changes in life expectancy at birth. In 1910, life expectancy at birth for males was 46.3 years and for females 48.3 years. By 1973, life expectancy had increased to 67.6 years for men and 75.3 years for women (World Almanac, 1975).

The achievement of these gains in life expectancy has been accompanied by the development of innumerable organizations which are collectively referred to as the health care system. This study delineates the particular role of hospital administrators within the context of a modern health care system with selected comparative data for long term care administrators, clinic managers, and HMO administrators.

THE CONCEPT OF ROLE

The concept of role has its origins in the theater and initially meant the part or character represented by an actor. Within social science literature and research, the concept is relatively new. But since Linton's (1936) work, hundreds of research studies have investigated various aspects of roles, often using varying definitions. Within a systems framework of analysis, the concept of role "is at once the building block of social systems and the summation of the requirements with which the system confronts the individual member" (Katz and Kahn, 1966, p. 171). In a sense, a system is a set of roles whose activities intersect and the role occupants are those individuals who perform the input, transformation, and output processing of the system.

Many interpretations have been placed upon the concept of role since it is such a useful idea for analyzing organizations and systems. Originally, role referred to conduct which conformed to a theatrical part or position rather than to the personality or style of the player who read or recited the part (Sarbin and Allen, 1964). Gradually, the meaning of role was expanded so that there are at least three senses of the term "role" in use. Roles may mean:

> 1. The demands of a position - that is, the norms, status, expectations, responsibilities, or position stemming from other persons (role senders) relevant to the actor (focal person or role incumbent); demands are characteristic of organizationally defined roles;
>
> 2. The orientation, conception, or perception of the part the incumbent person is to play - that is, the personal role definition of the focal person;
>
> 3. The activities and performance of the focal person - that is, the actual role behavior.
>
> (Levinson, 1959)

Unfortunately, it is not always clear what definition any author is using when he talks about the concept of role so the organizational role definition, personal role definition, and actual behavior involved with any single role often mix together. Some sorting out of these approaches is attempted in the following paragraphs, however.

Organizational Role Definition

In its most simple context, the role demand concept can be equated to a job description or specification set forth by an organization or an individual superior to the focal person. Lindgren (1969) suggested that the "individual's status and the roles appropriate to that status affect attitudes, values, personality, and behavior in general" (p. 272). Newcomb (1950) suggested that "positions are always associated with roles" and that "a role is the dynamic aspect of status" (p. 280). Linton (1945) presented similar ideas. Katz and Kahn (1966) said: "There is relatively little problem about understanding what the role requirements are in most systems because of their specificity." (p. 37).

It has become fashionable to speak of role demands in terms of a person's role set. Representative of this approach is Merton (1957). In fact, he was the first to articulate the concept. Due to the significance of the role-set concept, we will quote Merton at some length.

> However much they may differ in other respects, contemporary sociological theorists are largely at one in adopting the premise that social statuses and social roles comprise major building blocks of social structure. This has been the case, since the influential writings of Ralph Linton on the subject, a generation ago. By status, and T.H. Marshall has indicated the great diversity of meanings attached to this term since the time of the Maine, Linton meant a position in a social system involving designated right obligations; by role, the behavior orientation to these patterned expectations of others. In these terms, status and roles become concepts serving to connect culturally defined expectations with the patterned conduct and relationships which make up a social structure...

> Unlike Linton, I begin with the premise that each social status involves not a single associated role, but an array of roles. This basic feature of social structure can be registered by the distinctive but not formidable term, role-set. I mean that complement of role-relationships in which persons are involved by virtue of occupying a particular social status. (p. 110).

In a practical application of the role demand concept, Rowbotton, _et_ _al_., (1973), reporting on the work in English hospitals directed by Elliot Jacques, described "role...as a set of expectations of behavior in a given social situation." Expanding upon this general definition with more specific definitions concerning organizational roles, they proposed that organizational roles can be explored and defined in terms of:

> 1. The _duties_ or _functions_ which fall to the occupant;
> 2. The _discretion_ or _authority_ available in carrying out these and the various limits to it which exist;
> 3. (sometimes) the particular _tasks_ which structure activity in the role;
> 4. The _accountability_ of the occupant for his performance (p. 271).

These definitions were operationalized in their study of hospitals in terms of interrelated roles. Each role was described in terms of:

> 1. The functions or duties to be performed, broken if desired into the kinds of tasks to which they give rise;
> 2. The authority of the occupant, i.e., his right to act at his own discretion, within limits;
> 3. The accountability of the occupant for his performance.

Together, the roles added to a structure whose total effect can be compared with the overriding objects to be achieved. "The prime test of the efficacy of the total role-structure is whether it does or does not truly and economically achieve the objects, whatever these are agreed to be" (p. 31).

These researchers identified five dominant relationships in the English hospital. There were: (1) superior-subordinate (or managerial); (2) supervisory; (3) coordinating; (4) monitoring; and (5) collateral, service, and similar colleague type relationships. Note that all but supervisory are considered to be administrative roles. The literature on administration is extensive relative to the utilization of role demands upon personnel in organizations. For example, Prien and Ronan (1971) included 70 citations in their review of the literature on job descriptions. As this suggests, much of the emphasis has been upon formal specification of job demands. However, since the famous Hawthorne Studies in the early 1930's, innumerable items in the literature have been directed to the informal organization and the demands made by peers and other similar people who are not in a hierarchical relationship to the employee; hence, the concept of role-set is useful in explaining the organizational demands made upon individual employees or the actors in the system or subsystem because it includes all people who are involved in establishing expectations.

Personal Role Definition

The second general definition of role as orientation, conceptions, or perceptions has been used less frequently. However, a large number of "self-report" studies have been completed where the role incumbent is asked to indicate the role components of his job. Generally, this definition is concerned with role-taking. Turner (1956) commented that:

> Role-taking may proceed from identifying a position to inferring its role and in this manner anticipating the behavior of an individual. Or it may proceed from observing a segment of behavior to identifying the feelings or motives behind the behavior or anticipating subsequent behavior. In either case certain actions are interpreted or anticipated upon the basis of the entire role of which they are assumed to be a part (p. 318).

Perhaps a dominant reason for not dealing with role conceptions or perceptions is due to the separation between Sociology and Psychology. In part, this stems from the acceptance of Parson's theory of Society and Man which emphasized society as a proper unit of investigation for sociologists. Wrong (1961), for example, pointed out the overintegrated view of society and the oversocialized view of man which came forth from Parson's theory as presenting obstacles in role analysis. Coulson (1972) discusses criticisms made of the concept of role:

> To begin with, role analysis is said to obscure and neglect the importance of individuality. "Is there no man behind the mask?" ask the critics. Are men so programmed and passive that sociologists can afford to neglect the intrusion of self into the role or the individual innovations which may inaugurate social changes? (Bradbury *et al.*, 1972).

Most of the critics do not reject the concept of role. However, there are three major criticisms of role analysis. These are described in Komarovsky's presidential address to the American Sociological Association in 1973:

> The concept of role with its reliance on the view of man as a role conformer and of society as an integrated system is a distortion. It is time that these inadequacies were recognized and the concept of role was abandoned by sociologists. Without it we are able to examine the relationships between expectations which members of different groups hold of the incumbents of a particular position in a more flexible and dynamic way.

And again,

> Are [roles] not played parts in a play being written in the act of being played? Do they not contain marks of individuality? (Naegele, 1960).
>
> The second criticism alleges that role conformity and stability have been overemphasized and, conversely, that deviation, malintegration and social changes have been minimized or neglected.

> The third criticism focuses less on the extent of role conformity than on explaining such conformity as does exist. In the phrase of Blake and Davis (1964), traditional role analysis is characterized by the "fallacy of normative determinism," an assumption that the major explanation of conformity to roles, and, indeed, of the existence of social order, is to be found in the internalization of social norms (pp. 650-651).

Goode (1960) suggested that the role relationship be viewed as a transaction or a bargain where the individual allocates his resources among the obligations or expectations of others, the role senders, as he views the potential penalties or rewards available to be exercised by members of his role set rather than as a given that he cannot alter in terms of his perceptions.

The problem that is being discussed at present among some theorists and researchers is whether the psychological aspects of the individual (personality, perceptions, etc.) enter as an independent variable or intervening variable. For Merton (1957), the individual perceptions were viewed as intervening variables. That is, it is the actor--not the role-set or role senders--who suffers or experiences role conflict or ambiguity. As Komarovsky (1973) explained: "...so far the psychological variables entered this structural model in the Durkheimian tradition of intervening variables, linking social facts, or as patterned psychic responses to social facts" (p. 652). The case can be made that psychological factors can enter the model as additional independent variables. An example of this approach was Smelser's (1961) laboratory studies. In this project, the dependent variable was problem solving ability. Participants were divided into dominant and submissive types on the basis of personality. Smelser concluded that the most productive group:

> ...was composed of pairs in which the dominant subject (as rated on the personality test) was assigned the dominant role... It was concluded that congruence of role and personality pattern within subject and

> complementarity of patterns as between subjects were major determining variables in cooperative achievement (p. 541).

Questions may be raised about the dependent variable, problem-solving ability. If the dependent variable had been creativity or new idea generation, dissimilar personality and behavior patterns might have produced better results. The key significant point, however, is that combining sociological and psychological variables in role analyses will result in more adequate explanations of the dependent variables of goals of the system. Therefore, such an analytical approach should be encouraged.

Role Behavior

The third usage of role in theory and research is that of role as actual activities, performance, or behavior of the focal person. There is some difference of opinion as to whether or not role should be used to refer only to expected behavior or to actual behavior as well. Newcomb (1950) stated:

> Role assignments, however, are standard for all occupants of a specified position. When we talk about roles we are referring to a set of behaviors which are expected of everyone in a particular position, regardless of who he is. When we use this concept we are not referring to the known way in which people differ as they take the same roles, or to the variations in their motivations and attitudes as they do so. Role is strictly a sociological concept; it purposely ignores individual, psychological facts. Roles and prescribed roles, therefore, are not concepts which refer to actual behavior of any given individual.
>
> Role behavior, on the other hand, does refer to the actual behavior of specific individuals as they take roles. Mrs. John Doe, for example, binds up the wounds of her injured son, the Reverend James Smith pronounces the benediction at the Easter Sunday Service. These are

> single motive patterns, not roles. Mrs. Doe and the Reverend Smith each is said to be taking a role, but each motive pattern involved in doing so constitutes not a role but a role behavior. A role behavior is thus a motive pattern on the part of a specific individual as he takes a role. A role behavior has all the characteristics of any motive pattern. It also has additional characteristics, because it is behavior both determined by and perceived in terms of shared frames of reference (pp. 229--330).

Lieberman (1956) took a similar position when he said: "Role may be defined as a set of behaviors that are expected of people who occupy a certain position in a social system." Turner (1956) held a similar but somewhat deviant position in that he focused upon the behavioral components of role as a collection of behavioral patterns.

> By role we mean a collection of patterns of behavior which are thought to constitute a meaningful unit and deemed appropriate to a person occupying a particular status in society (e.g., doctor or father), occupying an informally defined position in interpersonal relations (e.g., leader or compromiser), or identified with a particular value in society (e.g., honest man or patriot). We shall stress the point that a role consists of behaviors which are regarded as making up a meaningful unit (pp. 316-317).

Katz and Kahn (1966) reviewed role behavior as standardized or institutionalized behavior. Haas (1964) stated that "it should be noted that this term [role] has been variously used to refer to both actual behavior, as well as expected conduct" (p.1). As Levinson (1959) observed, this dual conceptualization may be the most significant aspect of role. Indeed, it may be the place where the sociologist and psychologist come together. He said:

> From a socio-psychological point of view, one of its [role] most alluring qualities is its double reference to the individual and to the collective matrix. The concept of role concerns the thoughts and actions of individuals, and, at the same time, it points up the influence upon the individual of socially patterned demands and standardizing forces (p. 170).

Levinson (1959) continued his analyses by noting that there may not be a modal role type but several types:

> It is commonly assumed that there is great uniformity in role-performance among the members of a given position. Or, in other words, that there is a dominant, modal pattern of role-performance corresponding to the structural requirements. The rationale here parallels that given above for role conceptions. However, where individual variations in patterns of role-performance have been investigated, several modal types, rather than a single dominant pattern, were found (p. 176).

This idea has special significance for studies of administrative roles. Webb (1962) pointed out that external forces are also operating in role conceptualizations:

> But, because boys and teachers spend only about seven hours a day in the place, it is obviously not a closed system. Rather, it is in a two-way relationship with things outside, since it affects them and is itself affected by them. To look at it, therefore, only as a closed system, is to ignore part of the picture. Things outside must be taken into consideration, and in doing so, our assumption is that the two-way relationship must be, in most cases, harmonious, otherwise Black School would not survive (pp. 265-266).

Another important development in role definition was advanced by Leopold (1973) and is useful for research purposes and as an explanation for variation in role perception and role behavior:

> For operational purposes, representative role orientation is defined and analyzed in terms of two distinct component aspects: role perception and role behavior. This dual perspective grows out of role theory, particularly the writings of Levinson (1959) and Newcomb (1950), who regard a person's own role definition (or "role attitude") as an intervening variable between his official role prescription and his actual role performance. Merton's (1957) concept of "social orientation" suggests that the underlying theme containing the sources and the characteristics of a person's role perceptions and performance might appropriately be called "role orientation" (p. 697).

Thus, we note that role behavior is defined in terms of actual behavior and expected behavior. Probably a better approach is to utilize role perception and role behavior. This is useful in terms of the role receiver. The role sender gives the expected behavioral set. These ideas suggest that the concept of role has acquired a number of dimensions in its definitional formulations. This is to be expected as various researchers analyze their results. By way of summary, we quote Eisenstadt, et al., (1967), who specify various components of the definition of role:

> ...most of the definitions of "role" used in the various researches have some common denominators. Thus, they define "role" as a constellation of factors organizing an individual's behavior in society in some "general" socially approved patterns and goals.
>
> This "generalized" social behavior has been recognized as consisting of several components. Most of the definitions of the concept of role have emphasized some of the following components:
>
> 1. The "positional" or "situational" aspect - namely, the specification of some position or situation in the social structure, the incumbents of which are expected to perform a given role.
>
> 2. The "contents" of the role, usually defined as its goals or output.
>
> 3. The "exchange" aspect of the role, i.e., the specification of the relations with other people or other roles involved in the performance of the given role.
>
> 4. The "normative" aspect of the role, i.e., the fact that the specification of generalized goals and patterns of structural interaction and exchange are sanctioned, although to different degrees in terms of some of the norms and values in the society or its sections and that various types of sanctions are employed in order to uphold these normative injunctions.
>
> 5. It has also been emphasized that the goals and output of roles are related to, or derived from some basic "needs" or exigencies or social systems, and that they fulfill some functions for the maintenance of society (pp. 1-2).

REPRESENTATIVE RESEARCH PROJECTS

In this section, representative role research will be reviewed. The studies reviewed here are not directly related to the health industry but do show some of the various elements involved in role research. Health administration role research is reviewed in a later section.

One of the early research studies was the examination of the school superintendency role by Gross, Mason, and McEachern (1958). In this study, the authors attempted to "investigate (1) degrees of consensus (2) among certain populations of role definers (3) on certain segments of a role (4) at given levels of generality (5) under given rational and situational specifications of the position." (p. 74). Their instrumentation assessed: performance expectations - the obligation on the part of the role incumbent to do or not do a certain thing; attribute expectations - the qualities and/or attributes considered to be relevant to the role being defined; and participation expectations - the obligation on the part of the role incumbent regarding organizational members and activities. Role senders received primary emphasis in the study which, although criticized, has been recognized as a landmark study of roles.

Preiss and Ehrlich (1966) examined role theory utilizing the state police force of Nebraska as their subjects. Their theoretical analysis was based upon George Herbert Mead's work concerned with situational analysis. As Preiss and Ehrlich point out:

> The traditional framework for role theory received its earliest and historically most influential expression in the social psychology of George H. Mead. The general appeal of Mead to an interdisciplinary social psychology is perhaps best dramatized in this summary statement by Strauss (1956).

> Mead's writing offers a clear alternative to psychological theories based upon individualistic assumptions, principally through his insistence that individual acts are part of larger communal acts. In one way his stand is much like that of students of social organization (who also repudiate individualistic assumptions) but in another way it is not. Mead pictures social structures as somewhat less organized than do most sociologists and anthropologists (p. 161).

Other problems in role analysis identified by Preiss and Ehrlich included clarifying conditions under which failure to perform the role expected incurs sanctions (p. 173), establishing hard criteria for the identification of a role (p. 164), specifying the role unit (p. 164), and specifying the level of generality at which the sociologist-observer chooses to operate (p. 165).

Kahn, *et al.*, (1964), conducted an elaborate investigation of organizational stress in which managers were studied in terms of role conflict and role ambiguity. Role conflict was defined as being "caught in the middle" between two conflicting persons or factions. About 88 per cent of the subjects reported one of the people involved in conflict as being above them in the organization and about one-half saw the person as outside the organization. A dominant form of conflict, reported by fifty per cent of the subjects, was overload or conflict among legitimate tasks (pp. 379-380). Role ambiguity was found to be disturbing in four situations:

1. Uncertainty about the way a supervisor evaluates one's work;
2. Lack of identification of opportunities for advancement;
3. No clear understanding of scope of responsibility;
4. Expectation of superiors regarding one's performance.

Correlates of these role ambiguity situations were similar to those for role conflict and included "low job satisfaction, low self-confidence, a high sense of futility, and a high score on the tension index" (p. 380).

Stress and organizational size were related.

> The curve of stress begins to rise as we turn from tiny organizations to those of 50 or 100 persons, and the rising curve continues until we encounter the organizational giants. Only for organizations of more than 5,000 persons does the curve of stress level off - perhaps an organization so large represents some kind of psychological infinity and further increases are unfelt (p. 394).

The major organizational determinants of conflict and ambiguity included three kinds of role requirements:

> 1. The requirement for crossing organizational boundaries;
>
> 2. The requirement for producing innovative solutions to nonroutine problems;
>
> 3. The requirement for being responsible for the work of others (p. 381).

Kahn, et al. (1964) reported a number of additional findings and conclusions. The following three conclusions have special relevance to the role and position of health care administrators.

> The implications of the research project relative to the organization as a system include:
>
> a. To understand and predict a man's behavior on the job, we must ask to what other jobs he is connected (to what other persons he is connected) and what is the nature of the connecting bonds (formal authority, personal liking, task interdependence, and the like).
>
> b. To change the behavior of an individual or the content of a job involves complementary change on the part of all the "bondholders," the people to whom he is directly connected in the organization and who constitute his role set. Unless such complementary changes are carried through, there will be conditions of conflict or of ambiguity between the individual and the members of his role set.
>
> c. It follows that management should recognize the individual and the role set as the basic unit of which organizations are constructed. This is the

> minimum relevant group for decision making involving changes in the duties of any position in the organization. It follows also that each member of the organization should have the legitimate authority to convene the members of his role set to reach understanding and agreement regarding his duties (their role expectations of him) and his performance on the job (his role behavior) (p. 389).

Eisenstadt, et al., (1967), as a result of their review of research and theory on role analysis, reached the following conclusions:

> Perhaps the most important outcome of these considerations is that a role does not constitute a discrete habit or pattern of behavior, but a system in which different actors interact around the central focus of the output (or generalized goal) of the role according to the rules of interaction, exchange, and performance, upheld by sanctions and norms. Any such system is crystallized on several different levels, and although few systematic analyses of such levels exist in the literature, some common ground does exist, the most salient being the normative, the cognitive, and the technical levels.
>
> The normative level entails the definition of the components of the role in terms of the predominant norms and values and the legitimation and sanctioning of the patterns of rights and obligations assigned to the role.
>
> The cognitive level refers to the same components as perceived by the actor - i.e., the incumbent or incumbents of the roles. On this level it is possible to distinguish between the knowledge and intellectual perception of the role by the incumbent (of actions, norms, resources, etc.) and the expected or aspired. pattern of the role, namely, his "role-image" (this distinction is roughly equivalent to Kurt Lewin's "perceived and expected milieu")...The two patterns which make up this orientation - the perceived and the expected - are not necessarily always identical, and the particular relationship between them is a focal point of interest for consideration in empirical research.
>
> The technical level constitutes the actual pattern of behavior and activities of the incumbents of roles and of those with whom they interact in a systematic way in these capacities (pp. 2-3).

Kemper (1968) points out that there are three important reference groups which act together to foster achievement striving or aspirations so as to produce maximum performance levels. These are: (1) the normative group, (2) the role model, and (3) the audience. In his analysis, the normative group defines the role the individual is to assume, the model provides examples of how the role is to be performed, and the audience provides anticipation of rewards for outstanding performance in the role.

Little attention has been placed upon longitudinal studies or change and innovation in role analyses. Therefore, it is appropriate that some observations and research projects devoted to innovation be included as samples of representative projects. Schein (1971) argued that the professional is often unprepared to meet the demands which society places upon him and that scientific knowledge and technology have more than kept pace in the professions. However, he did point out that there are problems in the occupational socialization process which provide the person with his or her motives, values, ethical standards, and norms of where, how, and on whom to practice. Schein used doctors as his reference point, but his concepts are applicable to all professions.

Schein suggested that a person can pursue three broadly different types of careers (in any profession):

> 1. Custodianship
>
> This type of career is characterized by the total acceptance on the part of the practitioner of the currently existing norms of that profession, and by the practitioner's basic acceptance of the current levels of knowledge and skill in that profession. He is content to use his technical training in the performance of a traditionally defined role; he works hard at maintaining present professional norms; he accepts whatever licensing procedures may exist; and he favors the development of strong professional associations ruled essentially by elected colleagues.

> ### 2. Content Innovation
>
> This type of career is characterized by the acceptance of the traditional norms of the profession pertaining to practice, but by a dissatisfaction with the existing levels of knowledge and skill which underlie the profession. Thus, the content innovator will concentrate on science, technology, or scholarship to improve the knowledge base and technology which underlie the profession.
>
> ### 3. Role Innovation
>
> This type of career is hardest to describe because of its relative rarity and the ease of confusing it with *content* innovation. The essence of role innovation is a basic rejection of the norms which govern the *practice* of the profession combined with concern for the role of the professional in society. The role innovator redefines: (a) who is a legitimate client; (b) who can or should initiate the contact between client and practitioner; (c) what is an appropriate setting for conducting professional practice, and (d) what are the legitimate boundaries of the professional's area of expertise. Underlying each of these is a concern with making the profession more relevant to the pressing problems of society (pp. 521-522).

Schein explained how educational and other institutions can assist in role innovation. The following statement illustrates his ideas concerning role innovation and its implementation:

> I have argued that in our rapidly changing society, we will increasingly generate social problems which the professions, as presently constituted, will be unable to handle. Therefore, we must stimulate and make possible an increasing rate of role innovation in all the professions. Role innovation involves certain attitudes, values, and skills which can be developed and nurtured during professional school and in the early career. Such nurturance will require special efforts on the part of professional schools. Schools will have to employ faculties which are committed to *basic research*; they will have to put more emphasis on *inter-disciplinary curricula* and on *project-centered education* which will permit the growth of self-insight, self-confidence, diagnostic skill, and a humanistic value orientation; they will have to increase the use of the *applied*

> behavioral sciences in order to train skills of working in and with complex social systems; they will have to maintain a relationship with graduates through better career counseling, continuing education activities, and consulting services to alumni; and, finally, they will have to monitor more closely the operation of the profession through its licensing procedures, professional association, and other related activities (pp. 528-529).

Schoenherr and Greeley (1974) commented on the role commitment process as a part of role theory and analysis:

> Role commitment is a process which links a person to a position in a social system to the extent that the position provides him a favorable net balance of rewards over costs. Explanations of the relationship of human behavior to reward structures are basic to the social sciences, as Homans (1961) forcefully argues; and the consistency with which commitment studies extrapolate from general propositions dealing with costs and rewards is striking...A classic statement on the decision to continue participating in a system role is given in March and Simon's (1958) elaboration of the inducement-contribution theory of organization equilibrium. Becker (1960), too, defines commitment ultimately as an actor assessing the balance of costs over rewards realized from a series of seemingly unrelated "sidebets"; he concludes that the "classic simplicity of this economic example...shows us the skeleton" of the commitment process (pp. 407-408).

Schoenherr and Greeley (1974) showed in their research using Catholic priests as subjects that remaining in the role of priest depended upon the net balance of rewards and costs.

Brown (1973) commented regarding chief executive roles that:

> The unique role of the chief executive as a leader is to sustain, enhance, and project the personality of his organization through the impact of his own personality. If organizations are to be distinguished from machines and are to possess a human quality, the differentiation starts at the top. Subsidiary leaders can struggle to make a headless bureaucracy a friendly and comfortable place to work, but they cannot replace the influence of a corporate chief in demonstrating the purpose, traditions, standards, goals, and style of the whole organization (p. 36).

Mintzberg (1973) was of the opinion that the manager's job involved ten different roles which he grouped into interpersonal roles, informational roles, and decisional roles. Mintzberg argues that it is very difficult to divide up these roles as they form an integrated whole.

> In essence, the manager is an input-output system in which authority and status give rise to interpersonal relationships that lead to inputs (information) and these in turn lead to outputs (information and decisions) (p. 58).

While the preceeding litarature on role theory and research offers some potential insights for understanding the hospital administrator's role, there have been a number of studies focused specifically on hospital administration. These studies have generally attempted to describe, or in some cases, to prescribe the appropriate activities of a hospital chief executive. The literature on hospital administration presents an evolving view of what administrators do and why they do it in relation to various influences upon them. For purposes of analysis, this evolution of the field of hospital administration can be divided into three periods: a) the segmented closed health system; b) the segmented open health system; and c) the integrated health system. The overall trend in the evolution of the health care administrator's role has been toward increasing professionalization and an extended scope of responsibilities. Attention is directed primarily to the hospital administrator because of the primary role the hospital plays in the total health care system.

THE SEGMENTED CLOSED HEALTH SYSTEM

The segmented closed health system was the earliest and perhaps the most original form of health care organization. This system was characterized by large numbers of small, independently operated health facilities; and each unit such as a hospital tended to look inward with minimal active concern for external community needs or other agencies. Thus, segmented refers to the multi-part nature of the system, while closed refers to the general disinterest in external influences upon health care delivery. The hospital was one unit in this system co-equal with other health care deliverers. In effect, hospitals were one element within a "cottage industry" health care system; this segmented closed system existed well into the twentieth century.

Institutions resembling the hospitals of today have been recorded in early Egyptian and Indian civilizations, as well as Roman and Greek historical records. In the Christian era and into the Middle Ages, hospitals were part of the church. With the settlement of the United States, hospitals were started following traditional European lines. The administrator of these early hospitals was often a brother or a nun. Hospitals tended to have special purposes, such as service for the poor, orphans, or the treatment of particular diseases, such as leprosy, smallpox, or tuberculosis. The wealthy seldom used these hospitals, but were treated by physicians in their own homes (MacEachern, 1951).

After the Reformation the treatment of the diseased became more prevalent and physicians assumed both medical and administrative roles in hospitals. Typically these institutions were pest houses located so that minimal contact with "well" citizens was possible. During the latter part of the Nineteenth Century, many technical advances were made supporting the proposition that a hospital was a place for the patient to recover from his disease or wounds, rather than a place to die. Among these advances were the use of chloroform as an anesthetic, Pasteur's work on infection control, surgery, steam sterilization, and the X-ray, to name only a few.

The Crimean War had an important impact on the development of hospitals and their administration especially in terms of patient care and cleanliness. MacEachern (1951) suggested that Florence Nightingale was the first hospital administrator:

> Florence Nightingale was truly the first hospital administrator, a genius in organization. Later she extended her administrative duties to include planning the details of the sanitary engineering in a new military hospital. The culmination of her work came in 1860, after her return to England, when she founded the Nightingale School for nursing at St. Thomas' Hospital. From this school was graduated in 1863 a band of fifteen nurses who later became the pioneer heads of training schools throughout the world (p. 17).

The Civil War in the United States had a similar impact in terms of surgery and hospital buildings. Hospitals gradually became more complex organizations because of the changing philosophy of patient care, technical developments, the use of surgery to relieve pathological conditions and the possibility of recovery from many once fatal diseases. Because the physician's training was primarily in medicine and not management, it became customary to appoint assistants, often nurses, to carry out administrative duties.

In 1899, the Association of Hospital Superintendents was organized and in 1907 it became the American Hospital Association. Improving hospital management has been the primary concern of the association. A parallel group, the Catholic Hospital Association, was organized in 1915 and also focuses upon better patient care and administration. Another development in the evolution of hospitals was the organization of physicians into collective medical staffs. As more and more physicians became associated with hospitals and medical specialization advanced, it became increasingly difficult for the physician-administrator to possess the breadth and depth of knowledge to ensure quality control among the doctors associated with the hospital. The innovative concept of the medical staff was incorporated into the Hospital Standardization Program of the American College of Surgeons in 1918. Thus, the examination and evaluation of medical procedures and records became a function of the medical staff and not the administrator, especially in those hospitals meeting the standards of the American College of Surgeons. This elimination of medical quality control as a primary duty of the hospital administrator was a major turning point in the development of the non-medical management professional, the hospital administrator.

In 1922, a study was made of the training of hospital executives by a committee sponsored by the Rockefeller Foundation. This committee recommended that university courses should be offered to train hospital administrators. It is interesting to note that this committee allocated fifty per cent of course time to non-administrative courses in the social sciences, public health, hospital functions, history, and community health needs.

Recognizing the need for management skills in hospital administration, Marquette University established in 1925 a College of Hospital Administration designed to train hospital executives, technicians, dietitians, and other hospital specialists. However, the Marquette University program was terminated in 1927 because of funding problems.

The first degree granting program which still exists was that of the University of Chicago which began in 1934. Development of that program was slow, however, probably due to a reluctance to grant control to persons without medical training since traditionally administrators were either physicians or nurses. By the early 1950's, twelve universities granted degrees in hospital administration.

In 1933, the American College of Hospital Administrators was founded as the professional society of hospital administrators. In 1949, the Association of University Programs in Hospital Administration (AUPHA) was organized as the official accrediting agency of the college programs training hospital administrators, and was succeeded as the accrediting agency by the Accrediting Commission on Graduate Education for Hospital Administration in 1968.

The Administrative Role

As the role of the hospital administrator evolved in the early part of this century, expectations of the administrator also developed. MacEachern (1951) summarized the position of administrator or director in this way:

> At the head of the hospital, responsible for the physical plant and for every act committed therein, is the governing board. In direct charge. representing and responsible to the governing board, is the administrative officer, commonly called the superintendent but better designated as the director. The title, superintendent, implies only supervision, whereas director implies initiative and leadership as well as supervision, two qualities very necessary in the administrative head of the hospital (p. 85).

In 1948, a study report was released by a Joint Commission on Education sponsored by the American Hospital Association and supported by the W.K. Kellogg Foundation. As a part of their study, a representative sample of hospital administrators were asked what they did. The following items, as reported by Cunningham (1974) were identified in order of importance:

1. Working with the medical staff;
2. Managing personnel;
3. Checking on nursing and other hospital departments;
4. Planning for extension or improvement of services;
5. Managing business and money matters;
6. Pacifying the community and the public;
7. Planning and building new facilities;
8. Keeping trustees busy and quiet; and
9. Watching out for lawsuits (p. 50).

Two developments of major significance to health care systems occurred prior to the mid-twentieth century. The development for general, short-term hospitals of chief administrative officers who are principally trained in management rather than in medicine is perhaps the major development. The growth of university programs for training hospital administrators is of almost equal importance. The organization of health care systems themselves did not change significantly during this period but maintained a segmented closed system perspective. The general hospital was concerned primarily with its internal functioning and was not interested in related systems such as other hospitals, clinics, long-term care facilities, or preventive medicine. The possibility of an extended or integrated system was of little concern, and academic training programs typically focused on internal hospital operations rather than on linkages to broader community based total health care systems.

THE SEGMENTED OPEN HEALTH SYSTEM

During the second evolutionary period, beginning around 1950 and continuing into the late 1960's and early 1970's, the health care system, while remaining segmented, began to develop more openness to input exchange between various health care units. Little actual integration of the units occurred during this period, although future seeds for integration were being sown. The openness to other health care units in this period was especially developed in large urban hospitals as the realization occurred to many people that a "cottage industry" health delivery system was inadequate to meet the needs of urban communities. The institutional general hospital seemed a logical focus for care with its administrative, physical, and social resources already well-developed. The role of the hospital administrator in this period responded more slowly to the social realization that the hospital had multiple potential influences on health care. Administrators were still sorting out their different tasks, functions, and roles and attempting to develop normative statements about their behaviors.

Time Allocation Studies

A study by Connors and Hutts (1967) examined the role behavior of five top administrative personnel in a large teaching hospital. Among those whose activity schedule was reviewed were the administrator or director, three assistant administrators, and one junior assistant administrator. The results of this activity study are reported in Table III-1. The administrator (A) spent the greatest proportion of his time in health industry activities, whereas the rest of his time was spread over a multitude of areas. Assistant administrators tended to concentrate more in a narrow range of activities. For example, assistant administrator (B) concentrated upon departmental operations, administrative education, and physical facilities and equipment. This tendency indicates the roles of the assistants as specialists in contrast to the more general activities of the senior administrator.

The activities of these administrative personnel were also examined in terms of the functions of performing extramural tasks, controlling, planning, personal tasks, organizing, and directing and coordinating. Time allocations in percentage terms are summarized in Table III-2. The administrator spent a greater percentage of his time on extramural tasks, such as planning and organizing, while the others tended to focus on controlling, planning, and personal tasks. An exception was assistant administrator (D) whose assignment called for much attention to extramural tasks. A relatively small percentage of administrative time was devoted to directing and coordinating. Unfortunately, coordinating was not examined as a discrete function.

TABLE III-1: THE NATURE OF ADMINISTRATIVE ACTIVITIES

ACTIVITY	PER CENT OF TIME SPENT BY ADMINISTRATOR					AVERAGE
	A*	B**	C**	D**	E***	
Departmental operation (nonspecific)	10.8	22.2	31.6	10.1	7.7	16.5
Health industry activities	29.9	11.9	8.4	20.4	10.7	16.3
Administrative education	10.5	15.6	9.1	1.5	28.4	13.0
Public and community relations	2.8	4.9	2.2	31.5	5.6	9.4
Systems	1.9	7.6	14.0	2.1	18.9	8.9
Financial and business management	6.3	8.6	.7	13.9	11.9	8.2
Physical facilities and equipment	4.5	14.7	13.2	2.9	2.1	7.5
Group administrative meeting	8.2	7.0	3.8	7.4	11.2	7.7
Policy formulation and implementation	9.5	.8	4.1	2.9	--	3.5
Personnel management	1.0	1.8	5.5	1.4	1.5	2.2
Legal and governmental	1.6	.2	2.5	5.5	.7	2.1
Clinical service operation	4.1	2.3	1.4	--	.2	1.6
Administrative Research	4.5	.6	2.2	--	.2	1.5
Other	2.1	1.8	1.3	.4	.9	1.3
Medical Center operation (nonspecific)	2.3	--	--	--	--	.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Edward J. Connors and Joseph C. Hutts, "How Administrators Spend Their Day" Hospitals, J.A.H.A., February 16, 1967, Vol. 41, p. 48.

*A = Administrator or Director
**B = Assistant Administrator
**C = Assistant Administrator
**D = Assistant Administrator
***E = Junior Assistant Administrator

TABLE III-2: FUNCTIONS OF ADMINISTRATORS

FUNCTION	PER CENT OF TIME SPENT BY ADMINISTRATORS					AVERAGE
	A*	B**	C**	D**	E***	
Extramural	36.9	18.5	15.2	36.3	31.1	27.6
Controlling	16.5	28.2	32.9	13.7	24.4	23.2
Planning	25.8	22.2	23.3	17.6	20.2	21.8
Personal tasks	3.4	13.6	11.2	23.1	8.6	12.0
Organizing	12.9	9.5	8.9	3.6	4.3	7.8
Directing and Coordinating	4.5	8.0	8.5	5.7	11.4	7.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

*A = Administrator or Director
**B = Assistant Administrator
**C = Assistant Administrator
**D = Assistant Administrator
***E = Junior Assistant Administrator

Source: Edward J. Connors and Joseph C. Hutts, "How Administrators Spend Their Day," Hospitals, J.A.H.A., February 16, 1967, Vol. 41, p. 47.

Two additional time allocation studies have been conducted. Murray, et al. (1968) surveyed administrators of Catholic and non-Catholic hospitals and reported no significant differences between the two groups. A second study was reported by Norton (1972). The results of the Connors-Hutts, Murray et al., and Norton studies are compared in Table III-3. Some differences are evident. The time spent on the planning function is quite similar, but much more time is allocated to directing and coordinating by the administrator in the Norton study than in both the Murray et Al., and Connors studies. Also, much less time was devoted to extramural tasks in the Murray, et al., and Norton studies compared with the Connors-Hutt study. The Connors-Hutt study included only one chief administrator, whereas 24 were included in the Murray, et al., study and 19 in the Norton report. One would expect the latter two to be more representative of chief administrators' time allocation.

In a survey conducted by Davis and Henshaw (1974), graduates of the Columbia University Program in Health Services were contacted. Seventy-three per cent were chief executive officers and the balance were second level administrators. Activities (Table III-4) were ranked in terms of importance to the hospital, time spent on the activity, and the level of responsibility. One is impressed with the ranking of the financing decision area in first position in importance, whereas quality control, governing body, education, shared services, and research programs are at the bottom in importance, time spent, and level of responsibility. Medical staff relations were also determined to be of high importance.

In addition to classifying the hospital administrator's activities by management functions, clarifying the relationships he has with other personnel in the hospital is of equal importance for understanding the administrator's role.

TABLE III-3

COMPARISON OF TIME SPENT, EXPRESSED AS A PERCENTAGE, IN THE FUNCTIONS OF MANAGEMENT BY ADMINISTRATORS OF HOSPITALS OF 400+ BEDS AS REPORTED IN VARIOUS STUDIES

FUNCTIONS OF MANAGEMENT	CONNORS-HUTTS STUDY	MURRAY *ET AL.* STUDY	NORTON STUDY
Planning	25.8	29.9	23.7
Organizing	12.9	3.1	14.2
Directing and Coordinating	4.5	20.2	32.4
Controlling	16.5	7.8	12.4
Extramural Tasks	36.9	25.0	17.3
Personal Tasks	3.4	13.5	--
Operational	--	.5	--
Total	100.0%	100.0%	100.0%

Source: Norton, Malcolm E. How Administrators Spend Their Time. Trinity, Texas, Trinity University. Unpublished MS thesis, 1972. p. 44

TABLE III-4

RESULTS OF A SURVEY OF 161 COLUMBIA UNIVERSITY HOSPITAL ADMINISTRATION GRADUATES PERCEPTION OF IMPORTANCE TO HOSPITAL, TIME SPENT AND LEVEL OF RESPONSIBILITY FOR VARIOUS DECISION AREAS BY RANK

Decision Area	Importance to Hospital	Time Spent	Level of Responsibility
Financing (expenditures)	1	1	3
Medical staff relations	2	2	5
Physical plant, equipment, construction	$3\frac{1}{2}$	5	4
Health care delivery	$3\frac{1}{2}$	4	$7\frac{1}{2}$
Administration of professional departments	5	3	2
Financing (income)	7	8	1
Community relations	8	7	10
Outside agencies; governmental and voluntary	9	9	6
Quality control and evaluation	10	10	$7\frac{1}{2}$
Governing body	11	11	14
Legal aspects and litigation	12	13	13
Education programs	13	12	11
Shared services	14	14	12
Research programs	15	15	15

Source: Davis, Samuel and Stanley Henshaw. Decision Analysis in Hospital Administration: A Tool for Curriculum Revision, (monograph). Washington, D.C., Association of University Programs in Health Administration, One DuPont Circle, April, 1974, pp. 5 and 7.

Norton (1972) investigated these relationships and his findings are summarized in Table III-5. Over 50 per cent of the administrator's time was allocated to his direct associates, including being alone in his office. About 13 per cent of time was devoted to outside contacts and about 2 per cent with governmental representatives.

Norton also asked his 45 administrators whether or not they had experienced changes in managerial pattern, style, or time allocation. Sixty-four per cent answered in the affirmative. These changes were more apparent in the larger hospitals than the smaller or medium hospitals. The major reasons for the changes were increased requirements for planning, dictated by organizational changes, and compliance with new or revised governmental regulations. These findings are reported in Table III-6.

An interesting and potentially important question is whether or not there are differences between the time allocations of various studies of hospital administrators, as well as between studies of hospital chief executive officers and business executives. Five studies are compared in Table III-7. It is important to note that these studies were conducted at different times with different subjects and different methodologies. In a sense, we are comparing apples and oranges. At the same time, it is appropriate to ask what differences there may be. The wide variations between the studies of hospital administrators is notable and there are obvious differences between the functions of hospital administrators and business executives. What is discouraging is the lack of agreement about what functions administrators perform even within a given industry. Obviously, a comprehensive study is needed.

Prien and Ronan (1971) concur with this statement:

> The use of psychometric questionnaires in the future of describing jobs and to aid our understanding of work appears to be certain. In fact, the perplexing question

TABLE III-5

AVERAGE PER CENT OF TIME SPENT IN AVERAGE WORK WITH VARIOUS INDIVIDUALS

CONTACTS	PER CENT OF TIME
Immediate Administrative Staff	21.5%
Alone in Office	16.5
Department Heads	13.5
Medical Staff	11.2
Mixed Groups - Various Levels of Hospital	8.2
*Extramural - Institutional Related Persons	7.5
Governing Board of Hospital	6.0
Other Hospital Personnel - Individuals	5.8
*Extramural - Noninstitutional Related	5.2
Government Representatives (Local, State, or Federal)	2.4
Any Others Not Listed	2.2

*Extramural in this research refers to tasks or activities that are a vital part of hospital administrators, but have no direct relationship to the internal operation of the hospital. Includes institutes, association meetings, teaching and lecturing, and contacts with outside individuals and groups.

Source: Norton, Malcolm E. How Administrators Spend Their Time. Trinity, Texas; Trinity University, Unpublished MS thesis, 1972, p. 45.

TABLE III-6

REASONS IDENTIFIED BY ADMINISTRATORS FOR CHANGES IN MANAGERIAL PATTERN, STYLE, OR TIME ALLOCATION BY RANK ORDER

REASON CITED	NUMBER OF RESPONSES
Increased requirement for planning	8
Dictated by organizational changes	6
Compliance with new or revised governmental regulations	4
Voluntary managerial style changes	4
Extramural demands	2
Employee problems/demands	2
Health industry changes	1
Third party payer requirements	1
Compliance with standards of Joint Commission on Accreditation for Hospitals as pertains to Medical Records	1

Source: Norton, Malcolm E. How Administrators Spend Their Time. Trinity, Texas; Trinity University, Unpublished MS thesis, 1972, p. 35.

TABLE III-7

COMPARISON OF STUDIES OF VARIOUS CHIEF EXECUTIVE OFFICER FUNCTIONS IN VARIOUS INDUSTRIES

	NORTON 1972		MURRAY *ET AL.*, 1948		CONNORS-HUTTS 1967		MANAGERS BAEHR 1967	EXECUTIVES HEMPHILL 1960
	RANK	PER CENT	RANK	PER CENT	RANK	PER CENT	RANK	RANK
Policy Formulation and Implementation	1	20.5	13	1.3	4	9.5	1. Setting Organizational Objective	F. Long Range Planning
Financial and Business Management	2	13.0	8	4.4	6	6.3	----	----
Group Administrative Meetings	3	11.2	11	2.6	13	1.0	6. Developing Group Cooperation & Teamwork	----
Physical Plant and Equipment	4	9.1	9	4.0	3	10.8	----	----
Department Operations	5	8.8	7	4.8	9	4.1	2. Improving Work Procedures	A. Staff Services
Health Industry Activities	6	8.2	4	10.4	7	4.5	12. Handling Outside	H. Business Reputation
Clinical Services Operations	7	6.5	12	1.8	5	8.2	7. Coping w/ difficulties and Emergencies	C. Maintaining Business Control
Personnel Management	8	5.6	5	7.7	2	15.0	9. Supervisory Practices	B. Supervision of Work
Public and Community Relations	9	5.1	10	3.1	12	1.6	11. Promoting Community Organization Relations	E. Human, Community, & Social Affairs
Education & Research	10	4.6	6	7.1	10	2.8	10. Self Development & Improvement	----
Legal and Government	11	3.7	2	11.1	1	29.9	----	----
Other	12	3.7	3	15.1	8	4.4	----	----
Systems	--	--	1	26.6	11	1.9	----	----
Promoting Safety	--	--	--	--	--	--	3. Promoting Safety	----
Development & Technical Idea	--	--	--	--	--	--	4. Development & Technical Idea	D. Technical Products & Markets
Judgement & Decision Making	--	--	--	--	--	--	5. Judgement & Decision Making	C/B. Power & Authority
Developing Employee Potential	--	--	--	--	--	--	8. Developing Employee Potential	----
Personal Demands	--	--	--	--	--	--	----	I. Personal Demands
Preservation of Assets	--	--	--	--	--	--	----	J. Preservation of Assets

Sources: Norton, Malcolm E. How Administrators Spend Their Time. Trinity, Texas; Trinity University. Unpublished MS Thesis, 1972.

Murray, R.T., *et al.*, "How Administrators Spend Their Time: Research Report," Hospital Progress, Vol. 49, 1968.

Connors, Edward J. and Joseph C. Hutts, "How Administrators Spend Their Day," Hospitals J.A.H.A., Vol. 41, February 16, 1967.

Baehr, Melany E. A Factorial Framework of Job Description, Industrial Relations Center, University of Chicago, 1967.

Hemphill, J.K. Dimensions of Executive Positions, Research Monograph Number 89, Bureau of Business Research, The Ohio State University, 1960.

> concerns why development of this essential measurement focus has been so little exploited, particularly considering the acknowledged difficulty inherent in criterion development and measurement, to cite just one paradox. Whole disciplines have mushroomed focusing on attitudes, values, performance, style, and motivation in relation to the work people do with only the slightest suggestion that understanding what the individuals do is at all salient. To these writers it would appear that any measurement, and certainly interpretation, is contingent upon a clear and concise description of the job being performed (p. 391).

We could continue our analyses of Table III-7, as well as belabor the problem of inconsistencies between the various studies of executives in hospitals, as well as for profit organizations. However, these approaches will not solve the problems. What is needed are studies using similar instrumentation together with a follow-up interview to ascertain why differences are present. Unfortunately, most researchers report their findings, but have neither the funds nor the inclination in some cases to pursue their studies in more depth.

The Normative Literature

The normative literature on the role of the hospital administrator in this period suggested that the business manager role emphasis was evolving toward an expanded set of role activities which were not yet clearly defined. MacLean (1949) expressed this feeling of change:

> Too often the board of trustees, the medical board, and a multitude of special and standing committees assume administrative functions to a degree that makes the superintendent [administrator] more of a clerk than a chief executive. The proper function of a board of trustees are legislative and judicial and that of the medical board and of committees is advisory. When this is recognized, the many executive and administrative duties may then be carried out more successfully by the paid chief executive and his staff (p. 87).

Troupin (1950) saw the expanded role of the hospital administrator as more concerned with coordination:

> His established function as the director of hospital plant, equipment, and staff...comprise his major activity. He will extend his duties as coordinator of services in the hospital to include the additional public services which the combination of hospital-health center will imply (p. 56).

Crosby (1948) expressed a similar point of view when he considered the administrator to be the "...catalyst between three groups: the medical staff, the governing board, and the public." Hutchins (1948) saw the role of the hospital administrator as more goal oriented:

> The highest function of the administrator is to seek to define, clarify, or discover the aim of his institution. The peculiarities of institutional administration relate both to the means and to the end. But the most difficult and most important problems are those which concern the end (p. 51).

Mills (1946) defined the goals or functions of the administrator in a similar way. The eight functions identified were:

> 1. Performing business functions - including admissions, credits and collections, purchasing, general accounting, housekeeping, plant operations, food service, and personal services to clients.
>
> 2. Operating an educational institution - training nurses, and other interns including administrators.
>
> 3. Maintaining a social service - providing free care for those who cannot afford it.
>
> 4. Running a physical plant - includes meeting technical changes in physical operations.
>
> 5. Operating a complex social institution concerned with both internal and external groups.
>
> 6. Providing leadership, direction, and inspiration to volunteer personnel.
>
> 7. Insuring that the hospital functions as a center of public health education, promoting health protection in the community.
>
> 8. The administrator must be able to focus all the strength and ability of this large institution on the needs of individual patients to the end that every patient may have the best care and service that the hospital and its staff can provide (p. 69).

Although these functions could also be considered to be hospital goals, they emphasize the need for a comprehensive approach to the role of the hospital administrator.

The internal operations' focus of these discussions of the hospital administrator's role is evident, but the development of a more open system was occasionally recognized. For example, Snoke (1955) suggested:

> The hospital administrator must assume his role not only in running the hospital as it exists today, but in helping to plan for its growth and entire relationship to the community, including the physicians, nursing groups, the health department, and other health agencies. He must be considered equal to other professional groups which are working in the hospital. We need individuals who can be regarded as professionals themselves - not as businessmen who happen to be working in a hospital. We need individuals who can supply vision, leadership, and interpretation to their boards of trustees which are usually composed of sincere and interested laymen (p. 61).

A substantial change in the role of the administrator necessitated changes in the role of the main governing body which had traditionally run hospitals, the board of trustees. This change called for more authority to be delegated by the trustees and for a broader role for the administrator. Roberts (1950) eloquently captured these problems when he asked:

> ...are directors, superintendents, administrators, managers--or whatever title serves the responsibility best--really functioning as such? In most cases they are not. Instead, they are like corks floating on a turbulent sea trying desperately to stay on top of the waves of opinion, whipped by the winds of governing board members, medical staff members, old and new personnel, public understanding, and fatigue. Until administrators can be secured by the anchor of sufficient weight of authority to withstand the buffeting from every direction and source, they will continue to float about, seeking that safe harbor where they may ride out the storms of criticism on a placid sea of tranquility and understanding (p. 18).

This problem of the administrator's lack of authority and prestige was recognized by a number of writers. One solution that was proposed was to change the relationship with the board of trustees. Cohodes (1962) suggested that the administrator should move rather carefully into a new role of leadership:

> He must lead the board of trustees while appearing to be led. He must guide the medical staff while appearing to be guided. He must steer the hospital clear of unreasonable indebtedness and move relentlessly toward improved patient care. He must do all these things at once and continually, while patients, personnel, and the public anxiously watch. Finally, if he is to hang around, he must accomplish these hazardous assignments with tacit, if not enthusiastic support of all groups involved, many of which he must frequently rebuff by the nature of his job (p. 82).

Wilensky (1962) also called for a move away from immersion in the business manager role. "The administrator who now finds himself completely immersed in accounting, personnel, purchasing, and housekeeping functions may delegate more of these tasks to administrative technicians and supervisors at a lower level (p. 22). He believed that the administrator must spend more of his time relating the hospital to the community and delegate internal business management to subordinates. This community service orientation would aid the professional role of the administrator.

Traxler (1964) took a similar position pointing out the difference between operative and administrative functions. Operative functions were related to the business management role while administrative functions were related to setting objectives and planning. Johns (1961) was of the opinion that the success of the hospital was related to the ability or caliber of the chief executive officer. Henle (1960) spoke of the hospital administrator as a "technical generalist:"

> The administrator does not have the technical competence to dictate and direct each operation; he cannot determine how pathological tests are to be run or the nature of post operative nursing. Yet he must know, in a sort of extrinsic way, to be sure, the results, actual and potential, of these operations and their proper contribution to the total work of the hospital (p. 39).

Wilensky (1962) identified and defined six types of administrative patterns which he believed were indicative of those found in hospitals:

1. Professionalism - the exercise of control, delegation of power to subordinates, executive for the board, and a liaison between the board and hospital.

2. Teamism - the encouragement of self-discipline and communication between the various units of the hospital.

3. Politicalism - internally the administrator views his role as conciliator.

4. Partisanism - enlarging the role of the hospital in the community and increasing his status through community support.

5. In-groupism - while the "in-group" is accepted, it is not necessarily accepted by the rest of the personnel.

6. De factoism - the administrator has left his position and authority.

Obviously, some of these types of administrators could hardly be called administrators at all.

Letourneau (1966) viewed the role of the administrator as one of coordination. He saw the hospital as a situation where diverse functions existed and coordination of these functions was primary.

> A hospital is a coherent organization composed of a shelter, equipment, materials and competent persons which offers living accomodations, nursing service and diagnostic and therapeutic services to sick, injured or disabled people upon the order of a licensed physician who is privileged to use the hospital facilities within the limitations of those privileges. Such an institution needs a skilled coordinator trained in the art and science of management of professional people, money, and materials. He is now known as a hospital administrator, but as the hospital gradually assumes the appearance and character of a business, he may soon be known as the hospital president like his counterpart in industry (p. 48).

Bennis (1960) took a similar position although he added the objective of bringing together the needs of the organization and the individual. He stated that the administrator "...has to be the juggler of a highly important set of functions and, most particularly, the relationship between the goals of the organization and the goals of the individual (p. 70).

Bachmeyer (1963) pointed out that the role of the administrator was changing from an internally-oriented to a more community-oriented one:

> He has had to delegate functions that he formerly carried out as part of his own routine. This has lead to a more formal reporting mechanism, so that the chief executive could quickly grasp changing trends within the hospital itself. Recognizing that the hospital is caught up by forces at work in the community, the administrator has been required to broaden his reading. He...has to be familiar with the activities of the surrounding hospitals. (p. 113)

A good summary statement of the role of administrator as coordinator was made by Lisewood (1963):

> The responsibility of the administrator is to see clearly the essentials of a problem; to apply his experiences and imagination to finding a solution; to decide on a course of action; to make clear to his staff what is expected of them; and then to delegate the responsibility and the necessary authority to resolve the problem (p. 35).

A small number of other authors saw the role of the hospital administrator as a planner. Of course, there is some overlap between the roles of coordinator and planner as Traxler (1961) indicated in his discussion of the goals of the hospital administrator:

> 1. He must learn to outline major long-term goals and objectives of the organization, his people, and himself.
>
> 2. He must try to determine how these goals conflict and work toward reconciling conflicts.
>
> 3. He must become a part of the administrative leadership of his community. He must think of himself as a professional administrator and not as the person who runs the hospital (p. 1961).

Brown (1960) felt that objectives were important considerations for the hospital administrator:

> The administrator needs to determine his goals and evaluate the opposition to them. He can thus accept, and even select, lesser results as progress toward larger goals. This permits him to maintain constant pressure toward the desired ends without allowing the pressure to explode into an open break. It also allows him, when necessary, to accept and attempt alternatives. (p. 90)

Bugbee (1959) saw the role of the hospital administrator in a state of change and believed that the coordinator role was obsolete. However, he did support the planning role:

> ...it is now obvious that the primary responsibility of hospital administration is no longer solely a matter of organizing and controlling facilities and personnel to provide care. Rather, administration today is first measured in terms of its objectives and its plan toward accomplishment. The administrator's job is to formulate a practical plan to advance the hospital's high purpose in meeting community needs for medical care. But he can develop such a plan with all those affected only if he is familiar not only with internal problems but also with external forces in the community and in the country as a whole (p. 7).

Although Bugbee was writing in 1959, his words have a surprisingly modern ring. As we shall see later on, he predicted changes such that administrators would be concerned not only with internal problems, but also external issues. One might expect that the internal coordinating role could be delegated as well as the business management role and further, concentration given to external affairs. Georgopoulos (1964) combined all these roles, but indicated that the administrator would remain ultimately responsible for the hospital:

> ...the role of the administrator will be mainly, distinctively, and above all, a coordinative and integrative role, and not a resident director's role, or a business manager's role, or a universal expert

> role. The administrator will be less concerned with technical matters, bookkeeping operations, and specific work problems that can be better handled at the point of their origins, and more concerned with overall standards and organizing principles. He will still be concerned with costs and balancing the budget, but the articulation of the organization system, as such, will constitute an even more important aspect of his role (p. 29).

Concern was also raised over the role of the administrator as a change agent. Brown (1961), for example, said: "The most important thing an administrator administers is change. In a real way, administration can be defined as the constant reconciliation of the organization to constantly recurring change" (p. 93). In implementing the change agent concept, Dimock (1957) presented his ideas about the nature of the administrative functions.

> To be an administrator at the highest level of organizational leadership requires first, a philosophical cast of mind accustomed to generalizing, a high intelligence, a free ranging imagination, a willingness and an ability to entertain new ideas, and a certain adventuresomeness. Second, in the area of negotiation, there is needed a facility in communication and an ability to deal with men. Third, at the level at which policy is translated into action, there must be an ability to relate the total program to particular jobs, a receptivity to executive direction combined with a willingness to assume responsibility, and understanding of the uses and limits of organization, and a facility for inspiring teamwork. Finally, underlying and permeating all these skills, there must be an appreciation of social, economic, and political relationships and a concern for bringing into administration the democratic spirit (p. 21).

Neuhauser (1972) recognized that the role of the hospital administrator was complex:

> Hospital administrators are attempting to manage one of the most complex organizational forms in existence. They must be skilled in different management styles, both participatory and hierarchical. They must maintain a high degree of differentiation along departmental lines and integrate them simultaneously (p. 25).

Griffith (1967) took a similar position:

> The new skills, however, deal less with people-as-people, the face-to-face negotiation where so many administrators were successful in the last two decades, and more with people-as-organization. The decisions and agreements made face-to-face are increasingly structured and supplemented by those made by representative groups (p. 127).

Of most significance in indicating the need for a change in the concept of the role of the hospital administrator is the change in the concept of a hospital system to a medical care system. Johnson (1972) said that: "As administrators, our issue is to move from being operators of support systems for medical care into becoming managers of medical care systems" (p. 16). He went on to explain in more detail the challenge facing administrators of the future:

> To move from today into tomorrow, hospital administrators must now accept the responsibilities and perils of leading a medical staff, trustees, hospital staff, and community that must be led before tomorrow arrives. Administrators now face a time to stand up while the house is counted. They have passed the day when boards of trustees could be looked to for local leadership, and administrators could gracefully pass the buck. Today, the buck is in the hands of hospital administration, and because it is there, sufficient leverage exists for major accomplishments (p. 17).

Perceived Roles

In addition to the studies of time allocations of administrators and the normative literature on hospital administrators' behaviors, other researchers have investigated the perceived roles and responses to change by hospital administrators. Whiting (1973) reported a study of hospital administrators' reactions to various possible organizational changes. Questionnaires were sent to 187 hospitals in Minnesota. The attitudes of the administrators toward the proposals are presented in Table III-8. The most agreement among the respondents was evidenced for the administrator providing community health care leadership. They were generally agreed that a "certificate of need" should be filed before expansion of facilities. Proposals regarding treating hospitals as a utility, utilizing external planning agencies and franchising of hospitals received little support.

Given the need for relationships with external groups, one can ask what the nature of those relationships should be. Hawkes (1961) suggested that the psychiatric administrator has three sets of relationships. He describes these as:

> 1. His relationship with sources of political, legal, and financial support, which makes his office locally legitimate and endows it with organizational authority.
>
> 2. His relationship with sources of technical and professional support, which give him professional authority, provide him with a hospital staff, and involve him in reciprocal rights and obligations with neighboring medical facilities.
>
> 3. His relationship with the problem population, potential or actual patients, plus the nonhospital persons involved. (p. 91)

What Hawkes (1961) is specifically suggesting is that the administrator is in a boundary position. He describes the boundary position as "an area of interaction between members and nonmembers of an organization, and is marked by inputs and/or outputs." He viewed this boundary position in conjunction with the three role relationship sets as:

> Thus a boundary in the financial sphere of operation would include, for example, interaction between the administrator and such "outside" persons as a board of trustees, and it would be marked by the input of money and of organizational authority for the administrator. A boundary in the medical sphere of operation would include interaction between the administrator and medical groups outside the hospital, and would be marked by the input of personnel, approved treatment procedures, and medical authority. A boundary in the

TABLE III-8

MINNESOTA HOSPITAL ADMINISTRATORS REACTIONS TO VARIOUS POTENTIAL ORGANIZATION CHANGES

	STATEMENT NUMBER*						
Extent of Agreement	1	2	3	4	5	6	7
Strongly Agree	50.8%	4.6%	.8%	6.8%	23.4%	11.4%	1.5%
Agree	46.2	28.0	15.9	25.8	55.3	56.1	32.6
Indifferent	2.3	13.7	15.9	18.2	4.6	11.4	13.6
Disagree	.7	43.9	52.3	39.4	12.1	18.9	9.1

*Key

1. The chief executive officer of a hospital has the responsibility of providing leadership to his community in matters of planning for its health and health care.

2. Hospitals should be considered as a public utility.

3. As public utilities hospitals should be so regulated.

4. Franchising of hospitals is essential to maintain order in the hospital industry.

5. Hospitals should be required to possess a "certificate of need" prior to the expansion of any service or facility.

6. An area-wide comprehensive health planning agency should possess formal authority to enforce those plans which it develops.

7. All health care services and facilities should come under the umbrella of some larger organization. as for example, an area health care corporation.

Source: Whiting, Roger N. "Suggested Organizational Changes for the Hospital Industry," Health Services Reports, Vol. 88, No. 8, October 1973, pp. 743-749.

> patient sphere of operation - and this is the most important boundary of all - is primarily interaction between hospital staff and problem population, and is marked by patient admission (input) and discharge (output)" (p. 97).

Hawkes said that these role relationships and the boundaries involved do suggest role conflict but at the same time provide the administrator with control:

> The role of the administrator takes on a dynamic quality when we see that he can move freely between fiscal and political support and patient treatment and care. He is a participant both in the economic-political groups that provide the hospital with financial and material resources and in the professional-technical groups that provide the hospital with personnel who treat patients.
>
> Traditionally, social scientists have viewed such roles, which are imbedded in two or more contexts, as providing role conflicts for their incumbents. This may be true of the psychiatric executive role, but the fact that the role is linked by implicit contract to both sectors also creates the possibility of increased power and control. The mental hospital administrator is able to exert control over each of the two important groups, because to each he is the only representative or main spokesman of the other one (p. 101).

Returning to the concerns with external relationships of administrators, it is interesting to ask how the general public (potential patients) views the hospital administrator. Boissoneau (1965) used a stratified quota sampling procedure to question residents of Gainsville, Florida about their awareness of hospital administrators. The respondents (107) were asked the question: "What are the duties of a hospital administrator?" All responses are tabulated in Table III-9, but it is important to point out that 32 said they performed managerial activities. Twenty-six said hospital administrators provided economical and efficient operation, but twenty-two respondents did not know what hospital administrators did.

The medical staff of the hospital has been referred to as a potential source of conflict for the administrator by some authors. Physicians have objectives at variance with administrators in that the physician expects

TABLE III-9

RESPONSES OF 107 INTERVIEWEES ABOUT THE DUTIES OF HOSPITAL ADMINISTRATORS

DUTY	NUMBER
Performed overall management	32
Provided economical and efficient operation	26
Don't know	22
Engaged in financial management	13
Ensured good patient care	9
Managed business affairs	9
Engaged in staffing and personnel management	8
Personally treated patients	3
Served community	3
Supervised employees	3
Assisted governing board with policy making	2
Coordinated activities	2
Engaged in outpatient and inpatient affairs	2
Ensured that rules and regulations were carried out	2
Devised admitting procedures	2
Handled complaints	2
Handled non-medical affairs	2
Kept records	2
Managed	2
Provided adequate facilities	2
Visited patients and made patient rounds	2
Acted as a trouble shooter	1
Directs doctors	1
Instilled harmony in organization	1

Source: Boissoniau, Robert A. "The Extent of Public Awareness of Hospital Administrators," Richmond, Virginia, Medical College of Virginia, MS thesis, March 1965.

excellent support services and costs tend to be secondary in importance. King (1962) suggested the hospital is "a unique sub-culture, a self-contained social universe, an internally diverse society within a society. It has two key phenomena: diffusion of authority and an excruciating struggle for occupational prestige" (p. 256). Turning to the role of the administrator himself, Corwin (1946) made a similar point:

> Hospital administration is one of the most complicated and difficult of all tasks. The position of administrator is "sui generis." In addition to possessing innate executive ability, the successful administrator must be a person of many talents and of diverse aptitudes. He is the intermediary between the governing board and the various staffs. He is the chief diplomatic officer and the public relations counsel (pp. 131-132).

Diplomatic solutions are made more difficult by internal differences of opinion within the hospital. As McKee (1970) said:

> One problem at the base of the hospitals' problems is the manner in which various segments differentially perceive themselves and others. Administrators, nurses, and physicians have all been shown to see the authority structure quite differently. Levels of who should have the power to decide, the power to make recommendations, express opinions, or not be involved were studied by Bates and White [1961] and it was found that each group assigned more authority to itself than the other groups were willing to assign it (p. 37).

In a similar study, Peters (1968) examined the administrator's role as perceived by the physician. Although there was divergence of opinion, the physician saw both an internal and external role for the administrator. As an institutional manager, "...his chief purpose is to stay within his four walls managing and controlling his organization through his own efforts. As an interpreter of the hospital to the community,...he spends time away from his institution working to achieve external objectives" (p. 7). The administrator may be perceived as filling both roles. There was a wide variation in perceptions by the physicians and a tendency to broaden the perception with age.

In a study conducted by Kaluzny and Veney (1972) concerning who influences decisions in hospitals, the only agreement reached among administrators, medical staff, department heads and trustees, was that administrators were an important influence in the appointment and promotion of administrative personnel and that trustees carried some weight. In other areas there was disagreement with the amount of influence of the administrator. Hennessey (1965) reported that:

> ...the really unique thing about the administrative role is not so much his lay board, although influencing and educating the group with power over one's own appointment is a subtle art, indeed. It is rather the nature of his interaction with the medical staff. In each of the three hospitals the administrator reported that significant portions of the medical staff as a group were either irresponsible or hostile toward him (p. 90).

Gordon (1964), looking at the nature of the voluntary hospital, saw a top management triangle. He stated that:

> ...the point, therefore, is that, in many hospitals, none of these groups is really "on top." The triangle has no single top and no single base. Professionally, the doctor is on top. Legally, the board is on top. In day-to-day affairs, frequently the administrator is on top - for one thing, because he is there more than anybody else (p. 71).

Data collected for the Commission on Education for Health Administration funded by the W.K. Kellogg Foundation assessed the similarity of management activities across four types of health institutions: 1. Hospitals; 2. Long term care facilities; 3. Clinics; and 4. Health maintenance organizations (Allison, Dowling and Munson, 1975). Activities performed by managers in all four institutions included:

1. Long range planning;
2. Public relations;
3. Recruiting professionals, physicians;
4. Decisions regarding professional/managerial salaries;
5. Promoting/rewarding professionals/managers;

6. Motivating/directing immediate subordinates;
7. Dealing with personal/interpersonal problems;
8. Decisions regarding new construction;
9. Decisions regarding changes in decision/authority structure;
10. Decisions regarding financial/managerial information systems;
11. Influencing decisions of board/owners.

Activities performed by hospital executives plus at least two of the other types of executives included:

1. Market research;
2. Lobbying; influencing ruling of government agencies;
3. Establish agreements with other health organizations;
4. Developing criteria/systems to control quality;
5. Influencing decisions made by the medical staff;
6. Arbitrate between policy-making groups.

Activities performed by hospital executives plus one other group included:

1. Product research;
2. Obtaining long-term capital;
3. Negotiating with powerful external organizations.

The hospital executive role was the most generic in that it contained all the core activities common to three or four of the roles and no activities unique to itself.

There is no question but that the role of the administrator has undergone many changes between the mid-twentieth century and the present. Beginning with a quest for professionalism and moving away from the business manager image, the administrator became responsible for coordinating hospital activities as well as becoming actively engaged in community health problems. Although his main focal point was on the hospital as a total system, he began to be involved in integrating the hospital into a total health care system. In this sense, the hospital is a component, but not the sole reference point.

In some hospitals, consideration is being given to outpatient components through clinics associated with hospitals, as well as long-term care facilities. Thus, the administrator of the health care system must be a planner in terms of total health care plans, as well as within the individual units themselves. Not only must one be in a position of coordinating various units within and between the health care system, he or she must also be an integrator. That is, the various units of the system must be integrated so that synergy results whereby the end result is greater than the sum of the parts. Finally, the administrator must be a change agent in order that goals and objectives of the system are achieved for both employees and patients, as well as the goals of physicians and trustees and the public in general.

Whether or not the hospital will evolve into a total health care system or a new superstructure organization which merges hospitals, clinics, long-term care facilities, and consumer education, remains to be seen. In any event, the need for administrators with increased breadth and depth of perception becomes increasingly clear. In the next section, representative literature is examined which looks to the future of the health care industry with special reference to the role of the administrator.

THE INTEGRATED HEALTH SYSTEM

The early segmented, closed health system of the years prior to World War II gave way in the next twenty-five year period to a segmented open health system marked to some extent by a vertical and horizontal integration of the various individual health care units into more coordinated and more complex health care conglomerates. In turn, the administrative skills required to operate this new institutional arrangement broadened successively throughout the second period of evolution. The question facing the third period, the present and future, is "Which way now?" Which way for health institutions and more importantly for this report, which way for administrators? Many authors have discussed and speculated on these directions for the future and their ideas are summarized in the following pages.

An appropriate place to begin this discussion of a future integrated health system is with a brief review of the historical concept of the hospital.

> Due to its beginnings as a community charity for the poor and hopelessly ill, the voluntary hospital has inherited a unique and ambiguous organization that is proving increasingly troublesome in its new role as a modern health center. It is a tripartite arrangement of trustees, administration, and medical staff, with the formal lines of authority often in conflict with realities.
>
> The roots of the design go back to eighteenth century Britain. There is generally no such three-cornered dispersion in the major continental hospitals usually run in a hierarchical fashion by full-time chiefs of medical services. A central feature of the Anglo-American institution (which can now be considered American only, as the British have abandoned the old structure) has been its use as a place for the private practitioner to bring his private patients for treatment, but where he had no administrative or financial responsibilities. In return for this privilege, the doctor usually donated care for the indigent who constituted the majority of the hospital's patients.
>
> The hospital's changed role and function, and its altered financial base, have made the old structure an anachronism. Health insurance, public medical programs, and new patterns of hospital use have, as indicated, transformed the large majority of admissions into paying patients. The dwindling proportion of indigent cases is now generally paid for, in part at least, by public funds. When Title XIX of the Social Security Act becomes fully operational, "free" care will virtually disappear, and every patient will be able to have his "own" doctor. The hospital is being changed into a community service organization (Somers & Somers, 1967, pp. 51-52).

It is difficult to overstate the significance of the changes in finances and the increased role of the public. A number of administrative changes are possible to deal with these problems. One, of course, is to follow the British approach and the early U.S. situation and place M.D.'s in administrative positions. In an environment where there is a shortage of physicians, this hardly appears to be feasible. The same would be true for making physicians employees of the hospital or health care system. This is a possibility for the long-run, but requires a significant social change which can only be implemented at a slow pace. However, the Health Maintenance Organization model does offer a prototype, although the rate of development has been very slow.

Another alternative would be to elect the chief executive officer to the board similar to the practice followed by American business. This change no doubt could also result in additional internal representatives on the board of directors as opposed to an external board of trustees as the governing body. Johnson (1970) pointed out that an administrator as a board member will have a stronger position when dealing with the physician. However, as Johnson (1970) concluded: "The heart of the matter is whether or not the functioning of the hospital is enhanced by including the chief executive as a member of the board" (p. 29).

Bennet (1974) saw several areas whereby responsible innovation is needed; among these areas were: (a) organizational structure and arrangements, (b) manpower utilization, (c) the management process, (d) the physician's responsibility in management, and (e) the role of the specialist. In discussing the involvement of physicians in developing the budget and operating plans, he wrote:

> A willingness on the part of administration is frought with uncertainty, because too many administrators still cling to the query: "Just who runs the hospital?" Obviously, this question is the language of traditional management, and it rests upon the concept that responsi-

> bility, and therefore, authority, cannot be shared. To the contrary, most observations show that responsibilities are diffused throughout the organization, and that they often move under the influence of changing conditions or demands (p. 18).

Mott (1971) suggested that the public might turn to the government to press for administrative changes and, hence, more control over hospitals:

> The inability of our health institutions to respond adequately to the need for fundamental changes in their structure and functioning has thrust the health field irretrievably into the political arena, for where else can the public turn but to its government? As is becoming increasingly clear, the conflict centers around four interrelated issues: (1) the equitable distribution of services, (2) the costs of services, (3) the quality of care, and (4) the role of the consumer of services. The existence and nature of these issues is indicative of the imbalance between public expectations and the performance of our health system. How they are being dealt with will tell us something about how our health institutions are being changed.

Somers and Somers (1967) suggested that the hospital would be a changing institution. In this change process, they foresaw two trends dominating:

> Two major patterns for the future hospital are evolving: (1) it will develop into a community health center capable of providing the full spectrum of care from early prevention to rehabilitation and long-term care; (2) it will become part of an integrated regional complex of medical care institutions with a medical school and one or more teaching hospitals at the core. Smaller institutions will become satellites, programmatically although not necessarily financially or administratively, of larger institutions (p. 279).

In a recent series of articles in professional journals, experts were asked to forecast the major issues for health care administrators in the 1980's. All three articles generally agreed that: 1) there will not be dramatic changes in the health care delivery system; 2) cost containment will still be a major issue; 3) quality assurance will receive more emphasis; 4) multi-facility organizations will become even more popular; 5) governmental regulation of the industry will continue to increase (Curry, 1977; Rummer, 1976; Moore, 1976).

In a comprehensive paper prepared for The Commission on Education for Health Administration, Janet Strauss (1975) made similar kinds of predictions concerning the complex nature of health delivery institutions. However, according to Cunningham (1974), the system would still have its recognizable units:

> The health system would remain diversified and pluralistic; the organizations and services to be administered would include group clinics, small and large hospitals, long-term care and mental health facilities, health departments, voluntary health agencies, comprehensive health planning agencies, environmental control agencies, insurance plans, and other specially designated agencies and programs (p. 51).

White (1971) discussed the changing role of the administrator in conjunction with changes in the health delivery system. He observed:

> When one examines the ways in which the role of the hospital administrator has been changing, two separate but overlapping developments can be discerned. The first is the emergence and expansion of the administrator's executive function as the hospital has grown in size and complexity. The other and more recent development is that of hospital administration away from a narrowly institutional focus toward a concern with providing a range of medical care services to the community as a whole. This latter has resulted from the changing function of the hospital from that of basically providing doctors' workshops to that of serving as health care centers for a region (pp. 51-52).

Arnold (1971) made similar points concerning what she called third and fourth types of health administrators. However, she dated the emergence of this type much earlier than our analysis suggests:

> A third type of health administrator (the medical care administrator) began to emerge in the 1950's as the development of "third-party" financing of health care began to increase. The curriculum for the specialty stemmed out from public health and hospital administration, but has emphasized insurance mechanisms and ways of organizing broad systems of health care. Although some of their faculty were pioneers, schools of public health were slow in developing this special interest.

> Recently, a fourth specialty known as health planning administration has begun to develop. Although schools of public health are the most active in this area, health planning curricula are found in schools of public administration and in other settings (p. 539).

Significant changes are occurring in the health care system. Cooperative and integrative skills are primary administrative needs in one approach called the consortium arrangement. Although such arrangements are present in Chicago and Detroit, the Hartford development will be reviewed. In Hartford, Connecticut, eight hospitals formed a consortium and agreed to share services, programs, and staff. Lewis (1974) points out that the eight hospitals agreed "to coordinate and further the health care, delivery, medical, educational, research, administrative and other activities of its members..." Five statements elaborate these objectives:

> 1. The highest possible quality of medical services at the lowest practical cost to all persons;
>
> 2. the most advanced, coordinated programs possible in the areas of preventive care and research;
>
> 3. The coordination of members' services to eliminate to the greatest degree both unnecessary duplication and incomplete coverage in the providing of services and facilities;
>
> 4. The greatest possible integration of educational programs in medicine, dentistry, nursing, and allied health;
>
> 5. The education of the public as to the health care needs of the community (p. 26).

The consortium is coordinated by a board composed of one administrator, one board member, and one physician from each of the eight hospitals. The University of Connecticut's Dean of the School of Medicine is also a member. A full-time executive director will report to this combined board.

One of the problems of the consortium was to persuade the medical staff that nothing of significance would be lost by becoming a member of the combined staff. At the time of writing of the article, a complete agreement had not been reached, although the consortium was organized. Lewis (1974) suggested that "the combined medical staff issue will probably be resolved under a system of having each doctor receive a primary appointment to the active medical staff of one hospital and secondary staff appointments - not courtesy appointments - at the other general hospitals" (p. 29). He also suggested that the

> Capital Area Health Consortium could become something of a buffer zone. It may not be a coincidence that the idea caught fire as the Social Security Amendments of 1972 became law, mandating more emphasis on planning and tying it to capital expenditures, establishing PSRO's, requiring budgeting and many other far-reaching federal regulatory measures for hospitals (p. 29).

Another possibility similar to the consortium arrangement is the unit management model. In this model, a central administrative unit provides managerial processes for the member hospitals. These models have been utilized by the Veterans Administration and some Catholic orders. A more recent model is the Lutheran Hospital Society of Southern California. In these situational models, a central organization provides administrators for the member hospitals, although the board of the local hospital controls its direction. The administrator reports to both the local board and the president of the central society or group. It is possible for eventual merger of all units, although, at present, this is unlikely.

Mention should also be made of the Ameriplan, Health Care Corporations, as proposed by a Special Committee on the Provision of Health Services, American

Hospital Association (1970). According to the report, the Health Care Corporation would have these characteristics:

> 1. Each Health Care Corporation would synthesize management, personnel, and facilities into a corporate structure with the capacity and responsibility to deliver the five components of comprehensive health care to the community: health maintenance, primary care, specialty care, restorative care, and health-related custodial care.
>
> 2. Health Care Corporations would cover the comprehensive health needs of every geographic area and of all of the population, with some Health Care Corporations spanning geographic and political boundaries where necessary to assure that all persons have access to care. All persons would have the opportunity and be encouraged to join Health Care Corporations.
>
> 3. The Health Care Corporation would assure optimum service to the community by physicians. Every practicing physician would have the opportunity to be affiliated with a Health Care Corporation, and physicians would have the opportunity and could accept the responsibility of participating in the management of Health Care Corporations (p. 7).

Another model other than the consortium or multiple hospital system involves the extension of facilities by a hospital either by merger, expansion or service agreements. For example, associated with the central general hospital may be a group practice clinic, ambulatory care facility, long-term care facility, consumer health care educational unit, and agreements with other hospitals for various kinds of services. Whatever integrated system may develop, it appears that changes in the administrator's role will certainly be forthcoming.

Levinson (1976) sees the hospital changing from a role-oriented organization to a task-oriented organization. The role-oriented organization is characterized by rules, regulations and well-defined roles. Self-sacrifice is highly valued in such organizations. The primary concern of role-oriented organizations is the activity derived from the practice of their roles. The task-oriented organizations are concerned with getting the job done. The highest value is placed on the superordinate goal, and everything is structured to serve task accomplishment. A matrix-type structure is typical of task-oriented organizations.

In Levinson's view, the implications for the administrator of this shift in orientation revolve around leadership:

> Increasingly as the task orientation becomes paramount, the role of the leader becomes more important and the administrator shifts from a detail-tending function to one which people recognize as central to their cohesion towards task accomplishment. Many of the conflicts about who should run what disappear as it becomes apparent that skills, not names of professions, are the causal variables in task accomplishment by teams of people (p. 87).

Similar views of the changing role of the hospital and administrator were expressed by Neuhauser (1972) who proposed structuring the hospital as a matrix organization and by Schulz and Johnson (1976) who stated, "The primary role of the administrator is to provide leadership and facilitation of operations toward appropriate goals."

Phillippe (1968) said that "the greatest need of all will be for administrators who can manage change." Reddin (1974) agreed with this concept and elaborated upon it.

> ...by the 1980's the truly professional administrator will emerge; change will be his stock in trade. The qualities that differentiate him will be those of intellect and behavioral flexibility. Administrators will be selected for intellectual capacity not for knowledge, because the latter is out of date in three years. Selections will be based on behavioral flexibility because the administrator will live in continuing change, which will affect him as much as others (p. 9).

Bailey (1973) suggests that the hospital administrator can guide his or her hospital to both accept and also influence change. In his opinion, the administrator's activities include: 1) development of a sound planning and decision-making process in the hospital, 2) the use of this process to determine and to meet the health care needs of a particular community, 3) coordination of the hospital's goals and services with those of other hospitals in the region, and 4) implementation of the means for sharing or aggregating services with other hospitals and institutions. Note the emphasis upon community involvement and shared services in these suggestions.

In a paper presented at the American Sociological Association, Veney and Kaluzny (1972) looked at six specific expectations of administrators and others. These were whether or not the administrator should: (1)seek out short-term state or federal funds, (2) encourage the formation of citizen advisory committees, (3) educate local physicians, (4) support local physicians if they oppose a program advocated by the organization, (5) seek out health problems that indicate a need for additional services, and (6) adopt health programs on the initiative of the community. They discovered considerable disagreement concerning expectations for administrators. Because administrator, physician, board members, and staff vary in standards of judgment for administrative behavior, effective administration is not only highly idiosyncratic, but is also likely to be accompanied by considerable controversy on basic issues of program implementation, consumer representation, and physician/hospital relations.

Student (1974) discussed the effects of five factors - familiarity, influence, testing, stress, and chance - on the implementation of cost containing innovations at a 290 bed hospital. Among his observations are the following:

> ...familiarity with a new idea will reduce resistance to it...an innovation's value is greatest when it is visible but not directly initiating.
>
> People accept change more readily if they have had an influence over both the change itself and over the process of implementing the change.
>
> The change agent, as well as his proposed changes, can expect to be tested. He continually must win respect and approval for his proposals.

> The probability that innovation will cause stress is directly related to the amount and degree of behavioral change required for the adoption of the innovations.
>
> Change is a factor which adds problems as well as opportunity for the exercise of rationality and control.

Etzioni (1974) discussed the need for accountability on the part of hospitals and hospital administrators. This is particularly true with reference to consumer groups. He favors what he calls the "guidance approach" which he explains as "...administrators respond to articulations of rights by the community, its leaders, the press, etc., that is, to claims of accountability. In part their accountability is circumscribed and delineated by the legalities and formalities of the state, etc." (p. 56).

All of this probably sounds very confusing for the practicing hospital administrator. However, as Gray (1972) suggested:

> The hospital administrator should be molding organizational theories to meet the needs of his problems. Organizational structures, leadership styles, controllership and other management problems must all be tailored to the environment in which they will exist.

It should also be kept in mind that change usually is a slow process and often we do not know that changes have occurred until one looks backward to where one has been.

The day of the governing board being concerned solely with financial matters, whether they be operating expenditures and revenues or capital funds, is gone. They are now clearly accountable to the public for a much broader role, one that encompasses the functioning of the medical staff. With this more comprehensive responsibility, there is a need for greater knowledge of the hospital. This need cannot be fulfilled by individual lay trustees becoming involved in day-to-day operations of the hospital. Instead, the administrator must be an increasingly proficient communicator of operational information pertinent to board review and decision. The complexity of the modern hospital necessitates able management, which can only be supplied by persons with appropriate education and experience in the health field. Solutions must be sought that enable the governing board to meet its expanded role and at the same time to stimulate improved standards of administrative performance. Of course, the administrator-board member provides one method for achieving this change. The key question is whether or not this combined role will also provide increased integrative ability.

It becomes apparent that the role of the administrator is influenced by forces both within and outside the organization with which he is associated. Furthermore, the role is very complicated and must be examined in relationship to the context as opposed to individual units. We still do not know all the ramifications of the role but we do know it has changed, particularly in terms of expansion. The causes of these changes need more clarification as well as better specification of the future. This is essential for educational programs training administrators, as well as for continuing education experiences for the practitioner.

CONCLUSIONS

Because of disagreements about one generally acceptable definition of role and the lack of prior research which offers a useful model pertinent to the hospital administrator, it is necessary to develop a relevant role model. This model should recognize variations between hospitals and multiple goals, embody systems concepts, be useful in longitudinal studies, and consider innovation or change in the administrator's role. The model is based upon the literature review outlined in this report and the personal knowledge and understanding of the health care industry. Although the model, as presented, utilizes the hospital as the focal point, it does have more general application to other types of health care facilities, such as clinics and long-term care facilities.

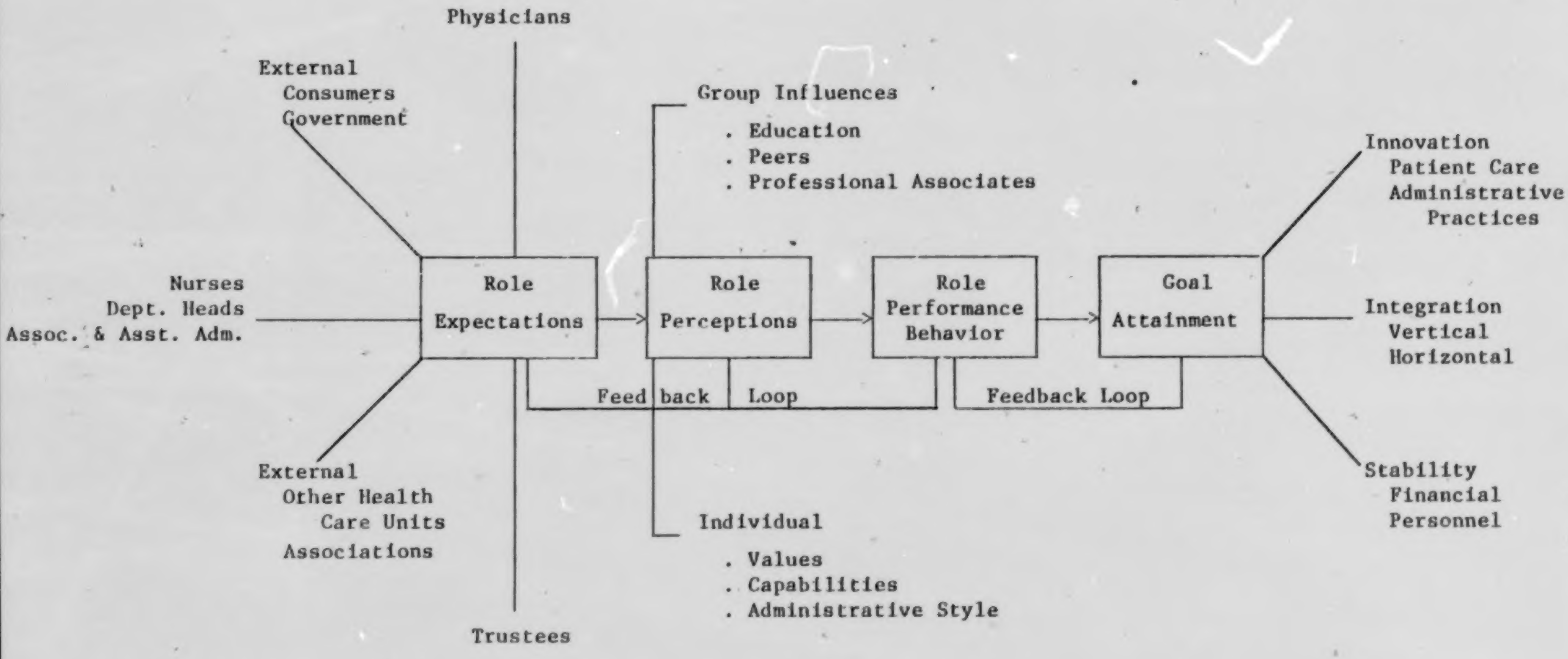
The model is presented in diagrammatic form in Figure III-1. The following paragraphs explain the various components of this hospital administrator role model.

Beginning at the left of Figure III-1, the typical role set encountered by the hospital administrator is identified. Internally, these include: physicians, associate and assistant administrators, department heads, nursing personnel, and trustees. Externally, we identify consumers and governmental laws and regulations, as well as other health care units. Depending upon the size of the hospital and the size of the community and related variables, there is, of course, considerable variation in the sent role which is identified as role expectations.

Role expectations are translated into role perceptions by the administrator. Role perceptions can be considered as intervening variables between role expectations and role performance behaviors. They are influenced by various groups, as well as by the individual role holder or administrator. Group influences include: educational experiences, the peer group of administrators in other hospitals, and professional associates including local, state, and national professional associations.

The third major variable in the model is role performance behaviors. Role performance behaviors include: subsidiary roles, such as that of business manager, coordinator, corporate head or team leader. Our historical summary points to changes in these key role concepts. Other sub-role components would include such activities as negotiating, monitoring, and evaluating managerial performance. We note that role performance has also been defined in terms of the functions of planning, organizing, assembling resources, staffing, and control. In other instances, role performance has been considered to be the

FIGURE III-1: HOSPITAL ADMINISTRATOR ROLE MODEL


Physicians
External
Consumers
Government
Group Influences
. Education
. Peers
. Professional Associates
Innovation
Patient Care
Administrative
Practices
Nurses
Dept. Heads
Assoc. & Asst. Adm.
Role
Expectations
Role
Perceptions
Role
Performance
Behavior
Goal
Attainment
Integration
Vertical
Horizontal
Feed back Loop
Feedback Loop
External
Other Health
Care Units
Associations
Individual
. Values
. Capabilities
. Administrative Style
Stability
Financial
Personnel
Trustees

tasks or activity behavioral patterns of the administrator. Although our model will accomodate all three of these definitions, we know in practice that there is considerable overlap between them. However, no one appears to have either investigated the overlap or determined which of the three definitional concepts has the greater explanatory power relative to goal attainment.

Note that our model has two feedback loops, one relating goal attainment to role performance and the second referring back to role perceptions from role performance and also relating back to role expectations. Thus, we account for learning by both the administrator and role senders, perceptual errors to be corrected, and changes in expectations to occur as various levels of goal attainment are achieved.

The output element or dependent variable is goal attainment. Goal attainment in this model is defined in terms of innovation, integration, and stability as the personal goals of the administrator for the hospital. Due to the significance of these elements, they are explained in some detail in the following paragraphs.

Two important goals of the hospital system are innovation and stability. Innovation or change can be described in terms of a biological model incorporating a natural order posture and also from the point of view of man introducing new ideas, procedures, and knowledge. We prefer the latter definition and utilize it in reference to new ideas, procedures, and knowledge relative to patient care and administrative practices. Stability is primarily concerned with man's attempt to control, order, and maintain the system.

However, there are two other developments in the health industry that not only are fascinating, but if continued will result in quite different systems. We will refer to these as "vertical integration" and "horizontal integration." Both are in progress in some hospitals and in almost every case, the hospital is the central focal point. That is, the hospital takes the initiative and is the primary integrator.

Vertical integration refers to serving a series of different kinds of patients or clients. Examples can be found of group practice clinics, ambulatory care facilities, long-term care units, apartments for senior citizens, and community health education units, all associated with the acute, general care hospital. Sometimes the relationship is very loose and informal so that the interrelationships are somewhat difficult to determine. The community health education or preventive medicine is the least developed. It can be expected that more attention will be devoted to this subject, particularly when the public is convinced that there are limits to being able to recover good health after the person is already ill. We suspect that the interested parties have not fully recognized the economics of scale and improved patient care associated with the vertical integration described here. Provided the theoretical potential advantages are actually present in practice, we suspect that more and more of these types of combinations will occur, especially if the increasing emphasis on cost containment continues and even increases in intensity.

Horizontal integration refers to the integration or combination of acute, general care hospitals. Presently, we see individual hospital agreements reached to share certain services such as laboratory or specialized intensive care units. Often these occur between the urban and rural hospitals. Sometimes, affiliation agreements are extended to include the rural physician in the urban hospital. A second possibility is the consortium agreement similar to those existing in Hartford, Detroit, and Chicago. Hospitals share services and facilities with a combined board composed of representatives from the affiliated hospital and which functions to resolve problems and foster integrated operations.

A third possibility is a merger involving a centralized management operation. Administrators of the local hospital report to both the local board and the executive director of the centralized management unit. Examples of this are found among some of the Lutheran hospitals in California. Catholic hospitals usually have a similar arrangement, although there is a move to more local decision-making and control.

A last possibility is the full corporate plan where hospitals are merged as local units of a large centralized administered unit. Examples of these are the for-profit hospital chains. Again, the goals of these types of mergers are improved patient care and cost containment. The goal of integration is the element to be attained.

All of these elements discussed in this section require additional research and analysis, particularly as each relates to the other. All are feasible and relevant, especially to an examination of the nature, causes, and prospective changes in the role of the health care administrator in the health care system with its special emphasis upon the acute, general care hospital.

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CHAPTER IV

SURVEY OF HEALTH SERVICES ADMINISTRATORS

Two objectives of the research contract were to:

1. Determine the nature of changes occurring in the present and future role of health care administration; and
2. Ascertain the causes of present and anticipated roles.

In addition to the literature described in the previous chapter, data were sought to meet these two objectives from two other sources: 1) a questionnaire survey of health services administrators including hospital, long-term care, clinic, and health maintenance organization executives; and 2) extended discussion format interviews with hospital executives and their senior staff associates, with other health care personnel external to the hospital such as planning agency, Professional Standards Review Organization, Health Maintenance Organization, and Blue Cross-type executives, and with health services administration educational personnel. Data developed from the questionnaire are reviewed in this chapter while data from the interviews are discussed in the next chapter. The discussion of all data related to educational considerations from both questionnaire and interview sources is reserved until Chapter VI.

In a certain sense, the interview and questionnaire data may be considered as two separate studies using two distinct methodologies to explore the same general areas of interest. The common link between the two sources of data is the Hospital Administrator Role Model described in the concluding section of Chapter III. The interviews were based in part on this model and the questionnaire was developed explicitly to provide information on the components of the model. This chapter is divided into three main sections: 1) descriptive information about the respondents and their institutions; 2) differences across institutions on relevant variables; and 3) differences within hospital and long-term care institutions related to the size of the institution, the education of the respondent, and the perceptions about future role change held by the respondent.

Complete information about the development of the questionnaire, sample selection, and the sample respondents is provided in Appendix A. Copies of each form of the questionnaire are included as Appendix B. To summarize the complete discussion of Appendix A, it appears that the hospital administrator respondents are representative of the distribution of all hospitals in the United States. Based on the similarity of response rates and sampling theory, it is likely that the other groups of questionnaire respondents are also representative of their respective populations. Given the limited number of health maintenance organization executives who were sampled and the correspondingly small number who responded, a number of data tables and the associated discussions omit these administrators.

SUMMARY OF FINDINGS

1. Role senders from within organizations, such as administrative staff and medical staff, are reported as having more influence on average than role senders outside the organization.
2. In the future, the influence of health planning agencies and the federal government is expected to increase greatly.
3. Quality patient care, recruitment and retention of professional staff, development of harmonious interpersonal relations among staff, cost containment, and good community relationships are among the five most important goals for hospital, long-term care, and clinic administrators.

4. Almost two-thirds of the hospital administrators believe their role will change, while only about one-half of long-term care, clinic, and HMO administrators expect a change in role.
5. Few differences exist across institutional settings in the managerial roles when broadly defined role categories are employed.
6. Hospital administrators emphasize policy related tasks and external representation, while clinic administrators engage in more operational activities, especially of a financial nature.
7. Administrators of larger hospitals rated policy activities higher in time consumed, importance, and anticipated importance, while administrators of small hospitals considered internal management more important in each category.
8. Long-term care administrators rated roles involving motivation and interpersonal relationships, and initiation of change as most important now and in the future.
9. Clinic administrators gave high ratings of present and anticipated importance to motivation, change initiation, information gathering, and negotiation roles.
10. Policy matters, senior level personnel management, and external affairs are the types of tasks which hospital and long-term care administrators perform directly themselves.
11. Regularly delegated tasks for all administrators include basic personnel program duties and patient care related activities.
12. No clear cut patterns of differences by education emerged.

I. DESCRIPTIVE INFORMATION

Table IV-1 presents average hospital data by bed size categories. Included are data about bed size and daily census, two common measures of hospital size. In addition, mean data from two questions designed to measure the extent of competition for the hospital are also summarized. These latter two questions were: "What is the approximate average geographic

TABLE IV-1

AVERAGE HOSPITAL DATA BY BED SIZE CATEGORIES

BED SIZE CATEGORIES	0-49	50-99	100-299	300+	TOTAL
NUMBER OF HOSPITALS REPORTING	33	240	321	158	752
%	4.39	31.91	42.69	21.01	100.00
NUMBER OF HOSPITALS REPORTING	33	240	321	158	752
AVERAGE NUMBER OF BEDS	35.94	71.90	172.16	564.77	216.67
STANDARD DEVIATION	9.899	14.372	55.793	332.466	242.853
NUMBER OF HOSPITALS REPORTING	32	233	308	150	723
AVERAGE DAILY CENSUS FOR 1975	23.09	48.94	128.30	469.05	168.76
STANDARD DEVIATION	12.09	14.68	52.02	332.64	221.51
NUMBER OF HOSPITALS REPORTING	32	208	276	127	643
AVERAGE EMERGENCY ROOM COVERAGE RADIUS (MILES)	19.25	24.55	25.84	27.20	25.36
STANDARD DEVIATION	11.659	18.085	23.498	32.751	23.704
NUMBER OF HOSPITALS REPORTING	28	203	290	132	653
AVERAGE ADDITIONAL EMERGENCY SERVICES WITHIN COVERAGE AREA	1.179	1.655	3.252	5.212	3.063
STANDARD DEVIATION	1.219	1.914	4.837	6.257	4.599

radius of coverage of your hospital's emergency room?_____miles" and "Within that area of coverage (question 6), how many other hospitals provide emergency medical services?_____" The mean bed size and census data indicate that the respondent hospitals are fairly representative of all United States hospitals. This issue is discussed further in Appendix A.

The extent of hospital competition is indicated by the lower two sections of the table. The average emergency room coverage of the hospitals does not vary substantially between the 50-99, 100-299, and 300 and over categories. Very small hospitals, under 50 beds, do have a somewhat lower coverage radius. On the other hand, the number of hospitals providing emergency services within the coverage area does substantially differ depending upon hospital size. This fact suggests that large hospitals are subject to more competition from other hospitals in their areas. Presumably also, the large hospitals are in larger metropolitan areas.

Tables IV-2 and IV-3 present similar data for long-term care facilities and for clinics whose executives responded to the questionnaire. The long-term care facilities show a similar pattern to the hospitals for similar organizations in the area--as size increases, number of organizations of similar type also increase. Clinics were divided into two categories--less than or more than 100,000 patient visits per year. Data for clinics are presented in Table IV-3. Again, the pattern of more competing organizations for larger size institutions is true.

Table IV-4 reports the management control type for the four types of respondents' organizations. The hospital respondents came most strongly (42.65%) from community hospitals (non-governmental, not-for-profit, non-church related). Second most frequent among the hospital respondents were state, county, and other non-federal, governmental hospitals. Sixty-six

TABLE IV-2

AVERAGE LONG TERM CARE DATA BY BED SIZE CATEGORIES

BED SIZE CATEGORIES	0-49	50-99	100-299	300+	TOTAL
NUMBER OF LONG TERM CARE FACILITIES REPORTING.	2	34	97	12	145
%	1.38	23.45	66.90	8.28	100.00
NUMBER OF LONG TERM CARE FACILITIES REPORTING.	2	34	97	12	145
AVERAGE NUMBER OF BEDS.	48.00	76.38	166.69	397.75	163.00
STANDARD DEVIATION.	1.414	15.463	51.768	81.468	94.366
NUMBER OF LONG TERM CARE FACILITIES REPORTING.	2	33	93	12	140
AVERAGE DAILY CENSUS FOR 1975.	46.00	71.73	155.44	365.83	152.18
STANDARD DEVIATION.	2.828	14.262	49.338	82.140	88.537
NUMBER OF LONG TERM CARE FACILITIES REPORTING.	1	30	83	9	123
AVERAGE ADDITIONAL ORGANIZATIONS PROVIDING SIMILAR SERVICES WITHIN GEOGRAPHIC AREA OF COVERAGE.	8.00	9.37	16.35	23.56	15.11
STANDARD DEVIATION.	-	15.925	36.516	25.274	31.83

148

149

TABLE IV-3

AVERAGE CLINIC DATA BY PATIENT VISIT CATEGORIES

Patient Visit Categories	0-100,000	100,000+	TOTAL
Number of Clinics Reporting	19	10	29
%	65.52	34.48	100.00
Number of Clinics Reporting	19	10	29
Average Number of Patient Visits--1975	45,195	155,358	83,182
Standard Deviation	22,221	74,746	70,377
Number of Clinics Reporting	13	9	22
Average Additional Organizations Providing Similar Services Within Geographic Area of Coverage	2.923	3.556	3.182
Standard Deviation	3.227	2.068	2.771

TABLE IV-4

ORGANIZATION MANAGEMENT

Management	Hospital Administrators		Long-Term Care Administrators		Clinic Administrators		HMO Administrators		Total	
	N	%	N	%	N	%	N	%	N	%
For Profit	39	5.26	95	65.97	31	100.00	0	00.00	165	17.84
Governmental-Federal [1]	0	00.00	0	00.00	0	00.00	0	00.00	0	00.00
Governmental-Non Federal (state, county, etc.)	229	30.90	7	4.86	0	00.00	0	00.00	236	25.51
Non-Governmental, Not-for-Profit (church related, etc.)	157	21.19	34	23.61	0	00.00	0	00.00	191	20.65
Non-Governmental, Not-for-Profit (non-church related)	316	42.65	8	5.56	0	00.00	9	100.00	333	36.00
TOTAL	741	100.00	144	100.00	31	100.00	9	100.00	925	100.00

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[1] No federal hospitals were included in the sample.

per cent of the long-term care administrators were from for-profit institutions, while all of the clinic managers were. All of the HMO administrators were from non-profit organizations.

Tables IV-5 and IV-6 indicate respectively the average number of positions in each type of organization and the number of positions which report directly to the chief executive officer. Table IV-5 shows that hospital administrators reported the largest mean number of governing board members followed by the HMO administrators, long-term care administrators, and clinic managers in order of decreasing mean Board size. These results conform with what one would project based upon the organizational control patterns--community based organizations will have larger boards than for-profit organizations.

Hospital administrators also reported the highest numbers of associate and assistant administrators with long-term care administrators reporting the second highest numbers. The same pattern is true for department heads. Total organizational employees in full-time equivalent numbers indicate that the hospitals again are largest followed by long-term care facilities. Table IV-6 reports the number of positions directly reporting to the chief executive. As expected, the pattern is quite similar to that shown in Table IV-5--hospitals have the most directly reporting positions followed by long-term care facilities, with clinics and HMO's with fewer positions on average.

Table IV-7 shows the number of chief executives reporting membership on their organization's Board of Trustees. Slightly over one quarter of the hospital and long-term care executives reported membership on their Board while just under one quarter of the HMO executives did. Few of the clinic administrators are on their Board, reflecting presumably the for-profit orientation of these organizations and the ownership and control by the clinics' medical staffs.

TABLE IV-5

AVERAGE NUMBER OF POSITIONS IN ORGANIZATIONS

	HOSPITAL ADMINISTRATORS			LONG-TERM CARE ADMINISTRATORS			CLINIC MANAGERS			HMO ADMINISTRATORS		
	N	MEAN	S.D.	N	MEAN	S.D.	N	MEAN	S.D.	N	MEAN	S.D.
Governing Board	714	13.16	9.410	106	9.73	14.213	24	5.21	3.476	9	12.44	7.108
Associate Administrator	250	1.40	1.386	25	1.12	0.332	3	0.67	0.577	3	1.00	0.000
Assistant Administrator	501	1.82	1.609	68	1.18	0.752	19	1.16	0.602	3	1.00	0.000
Department Heads	714	16.98	10.036	143	6.97	3.212	28	5.29	2.866	9	4.67	3.808
Medical Staff	605	82.14	115.430	107	11.50	20.180	16	26.31	24.450	8	93.50	161.140
Total Employees (full-time equivalents)	707	457.92	502.020	131	114.83	71.430	27	69.56	45.970	9	69.44	93.120

TABLE IV-6

AVERAGE NUMBER OF POSITIONS IN ORGANIZATIONS DIRECTLY REPORTING TO CHIEF EXECUTIVE

	HOSPITAL ADMINISTRATORS			LONG-TERM CARE ADMINISTRATORS			CLINIC MANAGERS			HMO ADMINISTRATORS		
	N	MEAN	S.D.	N	MEAN	S.D.	N	MEAN	S.D.	N	MEAN	S.D.
Associate Administrators	241	1.35	1.340	14	1.07	0.267	3	0.67	0.577	3	1.00	0.000
Assistant Administrators	472	1.49	1.224	60	1.13	0.676	18	1.17	0.618	3	1.00	0.00
Department Heads	662	8.47	5.080	130	6.32	2.947	25	4.48	1.939	6	5.33	3.559
Medical Staff	298	8.07	25.728	78	4.41	6.431	6	13.17	16.630	3	140.67	241.910

TABLE IV-7

MEMBERSHIP ON BOARD OF TRUSTEES

	YES		NO		TOTAL	
	N	%	N	%	N	%
Hospital Administrators	193	26.15	545	73.85	738	100.00
Long-Term Care Administrators	37	26.24	104	73.76	141	100.00
Clinic Administrators	1	3.23	30	96.77	31	100.00
HMO Administrators	2	22.22	7	77.78	9	100.00
TOTAL	233	25.35	686	74.65	919	100.00

Table IV-8 reports the number of respondents indicating they had job descriptions. Most hospital and long-term care administrators had job descriptions. Fewer HMO administrators did and only 19% of the clinic managers did. Table IV-9 reports the number of respondents who included job descriptions with their questionnaire response as requested. The hospital administrator job description information was discussed in Chapter II; not enough job descriptions for analysis were received from the other groups of executives.

Table IV-10 gives hospital administrators' mean age and tenure by hospital size categories. Administrators of large hospitals are slightly older on average and have held their jobs slightly longer. Administrators of small hospitals have held their positions the shortest amount of time, although the average tenure is still six years.

Table IV-11 reports the same data for long-term care administrators. Administrators of large long-term care facilities have held their jobs longer than administrators in small and medium-size facilities. Administrators of both large and small long-term care institutions are older than administrators of medium-size ones, however. The patterns are approximately the same as for the hospital administrators except for the higher age of administrators of small long-term care facilities. Table IV-12 presents data for clinic administrators. These administrators appear to have longer tenure than either hospital or long-term care administrators but their age does not appear substantially different.

TABLE IV-8

RESPONDENTS REPORTING JOB DESCRIPTIONS BY ADMINISTRATIVE GROUP

	Number Having Job Descriptions					
	Yes		No		Total	
	N	%	N	%	N	%
Hospital Administrators	614	82.97	126	17.03	740	100.00
Long-Term Care Administrators	134	92.41	11	7.59	145	100.00
Clinic Administrators	6	19.35	25	80.65	31	100.00
HMO Administrators	6	66.67	3	33.33	9	100.00
Total	760	82.16	165	17.84	925	100.00

TABLE IV-9

RESPONDENTS SENDING JOB DESCRIPTIONS BY ADMINISTRATIVE GROUP

	Number Sending Job Descriptions					
	Yes		No		Total	
	N	%	N	%	N	%
Hospital Administrators	144	19.46	596	80.54	740	100.00
Long-Term Care Administrators	22	15.17	123	84.83	145	100.00
Clinic Administrators	2	6.45	29	93.55	31	100.00
HMO Administrators	1	11.11	8	88.89	9	100.00
Total	169	18.27	756	81.73	925	100.00

TABLE IV-10

MEAN ADMINISTRATOR AGE AND TENURE BY SIZE HOSPITAL ADMINISTRATORS

	Hospital Size, Beds			
Number, Mean, Standard Dev.	50 - 99	100-299	300+	Total
Number of Administrators Reporting	240	321	158	719
Number of Administrators Reporting Tenure as Chief Executive Officer	240	319	157	716
Average Number of Years as Chief Executive Officer	6.037	7.060	8.331	6.996
Standard Deviation	5.535	6.504	7.436	6.467
Number of Administrators Reporting Their Age	229	306	153	688
Average Age	46.01	46.08	49.01	46.71
Standard Deviation	10.343	9.672	8.635	9.749

TABLE IV-11

MEAN ADMINISTRATOR AGE AND TENURE BY SIZE
LONG-TERM CARE ADMINISTRATORS

	Facility Size, Beds			
Number, Mean, Standard Dev.	50 - 99	100-299	300+	Total
Number of Administrators Reporting	34	97	12	143
Number of Administrators Reporting Tenure as Chief Executive Officer	34	96	12	142
Average Number of Years as Chief Executive Officer	6.765	6.490	8.250	6.704
Standard Deviation	4.200	6.065	6.355	5.683
Number of Administrators Reporting Their Age	31	91	12	134
Average Age	50.68	46.26	50.00	47.62
Standard Deviation	10.824	12.078	12.599	11.926

TABLE IV-12

MEAN ADMINISTRATOR AGE AND TENURE BY SIZE CLINIC ADMINISTRATORS

	Clinic Size, Patient Visits per Year		
Number, Mean, Standard Dev.	0-100,000	100,000+	Total
Number of Administrators Reporting	19	10	29
Number of Administrators Reporting Tenure as Chief Executive Officer	19	9	28
Average Number of Years as Chief Executive Officer	11.474	10.111	11.036
Standard Deviation	8.940	7.557	8.404
Number of Administrators Reporting Their Age	19	10	29
Average Age	47.37	46.10	46.93
Standard Deviation	11.256	9.024	10.392

Table IV-13 presents the mean ranks from responses to the following question:

Rank each of the following methods from most to least important in terms of how you can influence your organization's policy(1 is most important; 2 is next important; ... 6 is least important).

_____ Vote on Board of Trustees
_____ Preparation of specific studies for Board
_____ Personal and informal contacts with Board members
_____ References to literature, legislation, etc.
_____ Persuade physicians to recommend policies
_____ Other (please specify)

Very few responses to the other category were provided. Table IV-13 indicates that hospital administrators on average gave the highest rank to preparation of studies for the Board as a means of influence. This was followed by personal contacts with Board members, persuading physicians to recommend policies, reference to literature and legislation, and a vote on the Board, in that order. Thus, hospital administrators appear to be saying that data and personal contacts are the highest ranked means of influencing their organization's policy. Long-term care administrators follow the same pattern with somewhat less consensus.

Clinic administrators place more emphasis upon contacts with their Board members, probably because they are also the owners of the clinics. Studies for the Board, physician recommendations, literature and legislation, and a vote on the Board are the order of mean ranks for clinic administrators. HMO administrators believe their policy influence comes first through physician recommendations, then through contacts with Board members, studies for the Board, references to literature and legislation, and last, a vote on the Board. A vote on the Board of Trustees is seen as a relatively low ranked means of influence over policy by all the administrators. Data, in the form of studies for the Board, are perceived to be a highly ranked means of influence as are personal contacts with Board members or physicians.

TABLE IV-13

MEAN RANKS
EFFECTIVE POLICY INFLUENCE PROCEDURES

	HOSPITAL ADMINISTRATORS			LONG-TERM CARE ADMINISTRATORS			CLINIC ADMINISTRATORS			HMO ADMINISTRATORS			TOTAL		
	N	MEAN	S.D.	N	MEAN	S.D.	N	MEAN	S.D.	N	MEAN	S.D.	N	MEAN	S.D.
Vote on Board of Trustees	660	4.177	1.480	115	4.122	1.707	24	4.292	1.334	8	3.875	1.808	807	4.170	1.512
Preparation of Specific Studies For Board	698	1.871	1.116	126	2.317	1.407	29	2.103	0.860	9	2.889	1.364	862	1.955	1.171
Personal and Informal Contacts with Board Members	699	2.439	1.295	127	2.528	1.332	29	1.690	0.806	9	2.444	1.014	864	2.427	1.291
References to Literature, Legislation, etc.	699	3.589	1.149	128	3.133	1.264	28	4.000	0.770	7	3.286	1.254	862	3.532	1.170
Persuade Physicians to Recommend Policies	700	3.000	1.271	129	3.132	1.313	28	2.536	1.071	8	2.250	1.035	865	2.998	1.274

Table IV-14 presents a summary of administrators' educational backgrounds by the degrees received. Master's degrees in health administration are predominant among hospital administrators while infrequent among the other groups. Long-term care administrators most frequently have no degree or a Bachelor's or Master's in a non-health, non-business field. Clinic administrators most frequently have a Bachelor's degree in business.

Table IV-15 summarizes the responses to the question, "Do you believe your role (function) will change in the future?" Almost two-thirds of the hospital administrators believe their role will change while only one-half of the long-term care administrators believe their role will change. Slightly more than half of the clinic and HMO administrators expect their role to change.

SUMMARY: DESCRIPTIVE DATA

This section of Chapter IV has reviewed and summarized the descriptive or demographic data resulting from the questionnaire phase of the project. It was pointed out that there is reasonable confidence that the respondents to the study are representative of hospitals and hence chief executive officers of hospitals. Because there is no known universe generally recognized as such among long-term care, clinics, and HMO's, one cannot say that these respondents to the questionnaire phase are unquestionably representative. However, the data do represent samples of these groups and insofar as the universe from which the samples were drawn are representative, then these results are representative.

Bed size and average daily census are two measures of hospital size. In addition, respondents were asked to give the geographic radius of the hospital's emergency room and the number of other hospitals. Because size

TABLE IV-14

DEGREES RECEIVED

Degree-Major		No Degree	BA-MA	Other Advanced	MBA	MHA	BBA	Total
Hospital Administrators	N	74	116	37	32	358	105	722
	%	10.25	16.07	5.12	4.43	49.59	14.54	100.00
Long-Term Care Administrators	N	52	49	5	4	4	23	137
	%	37.95	35.77	3.65	2.92	2.92	16.79	100.00
Clinic Administrators	N	9	1	1	4	1	14	30
	%	30.00	3.33	3.33	13.33	3.33	46.68	100.00
Total	N	135	166	43	40	363	142	889
	%	15.19	18.67	4.84	4.50	40.83	15.97	100.00

TABLE IV-15

RESPONDENTS' BELIEFS REGARDING FUTURE ROLE CHANGE

	Believe That Role Will Change in Future					
	Yes		No		Total	
	N	%	N	%	N	%
Hospital Administrators	483	66.90	239	33.10	722	100.00
Long-Term Care Administrators	68	50.00	68	50.00	136	100.00
Clinic Administrators	17	56.67	13	43.33	30	100.00
HMO Administrators	5	55.56	4	44.44	9	100.00
Total	573	63.88	324	36.12	897	100.00

is a potential moderator variable in discussions of administrative roles, it will be further utilized in later sections of this chapter.

Most of the hospital respondents were from community hospitals. This was indeed expected. As was expected, the hospitals had more administrative staff (associate and assistant administrators) and department heads than other organizations. The mean number of governing board members was also greater. More hospital administrators were likely to be members of the Board of Trustees.

It was interesting to note that smaller and larger categories of long-term care facilities contained administrators with longer tenure. However, chief executive officers in middle-sized groups (100-299 beds) were younger. For hospitals, the larger the size category, the longer the tenure and this pattern was repeated in the average age classification although there was little difference between the smaller and middle-sized categories.

Hospital administrators believed the preparation of specific reports for the Board of Trustees gave them the greatest influence on organizational policy. Long-term care administrators agreed with this approach but clinic administrators placed more emphasis on contacts with Board members.

Master's degrees in health administration were prominent among hospital administrators whereas few graduate degrees were mentioned by other kinds of administrators. Clinic administrators often had a bachelor's degree in business.

Almost two-thirds of the hospital administrators believed their role will change in the future contrasted to about one-half of the long-term care, clinic, and HMO administrators.

II. DIFFERENCES ACROSS INSTITUTIONS

The Hospital Administrator Role Model described in the concluding sections of Chapter III formed the basis for the development of the Survey of Health Services Administrators. In addition to the descriptive data reviewed in the previous section, data were collected on the principal variables of the model, including role expectations, role perceptions, role performance behavior, and goal attainment. Role expectations data were determined by a question which sought to have the administrators indicate the degree of influence which certain groups had on the development of new patient care programs in their organizations. Respondents were also asked to indicate if they anticipated that a particular group would have greater influence in the future. Role perceptions data were determined from a question which asked the administrators to indicate the importance of particular goals in their organizations.

Role performance behavior questions involved managerial role descriptions, managerial activities/functions, and task activity divisions within the organization. All long-term care, clinic and HMO administrators responded to the managerial role descriptions and task activity division questions. Each of three subsets of the hospital administrators responded to one of the three sets of questions. Goal attainment data were derived from questions about the existence of, or plans for introduction of, management and health care programs into the hospital organizations. Only hospital administrators were asked these goal attainment questions. This section discusses differences among the hospital, long-term care, and clinic administrators on those components of the model for which responses were available for all three groups. HMO administrators are not discussed in these comparisons since the limited number of HMO respondents may not provide satisfactory values for analysis.

Role Expectations

Role expectations are determined by the sent role provided by members of the role occupant's role set. A critical question is how much influence do particular members of the role set have in determining the sent role. Table IV-16 presents the data from the three groups of administrators along with the F ratios from a one-way analysis of variance on the three groups and the associated significance probabilities. Many differences between the groups are significant.

Clinic administrators attribute significantly more influence to their Boards than do either of the other groups. Tables IV-17, 18, 19, and 20, providing tabulations of the responses, illustrate this even more clearly in that less than 40% of the other administrators checked major influence for their Board while over 81% of the clinic administrators did. Both clinic and hospital administrators feel that their medical staffs have a stronger influence than do long-term care administrators, who, of course, do not necessarily have permanent medical staff personnel.

By contrast, clinic respondents attributed less influence to their administrative staffs than either the hospital or long-term care administrators. The same pattern is true for department heads. It is likely that clinics have few individuals other than the administrator who is either an administrative staff member or department head. It is also likely that in clinics the medical staff has the principal influence on patient care program development rather than the administrative staff.

TABLE IV-16

ROLE SENDER DEGREE OF INFLUENCE ON PATIENT CARE PROGRAM DEVELOPMENT[1]

	HOSPITAL ADMINISTRATORS			LONG-TERM CARE ADMIN.			CLINIC ADMINISTRATORS				
	N	MEAN	S.D.	N	MEAN	S.D.	N	MEAN	S.D.	F-RATIO	SIGNIFICANCE PROBABILITY
Board	708	3.136	0.840	129	2.954	0.975	27	3.815	0.396	11.51	.000
Medical Staff	729	3.569	0.632	134	3.261	0.755	28	3.679	0.548	13.52	.000
Administrative Staff	719	3.701	0.567	138	3.754	0.510	27	3.074	0.781	17.00	.000
Department Heads	721	3.226	0.694	141	3.631	0.591	24	2.375	0.924	39.14	.000
Patients	719	2.636	0.820	136	2.934	0.862	26	2.808	0.801	7.74	.000
Professional Association[2]	717	2.011	0.819	139	2.547	0.886	24	2.458	0.721	26.61	.000
J.C.A.H.[3]	716	2.494	1.011	--	--	--	--	--	--	--	--
A.H.A.[3]	712	1.914	0.809	--	--	--	--	--	--	--	--
Blue Cross/Blue Shield	712	2.128	0.885	131	1.954	0.983	23	1.957	0.976	2.33	.098
Federal Government	721	2.653	0.997	138	3.196	0.878	25	1.800	0.707	29.38	.000
State/Local Government	717	2.484	0.965	138	3.196	0.903	25	1.760	0.723	41.95	.000
Community Interest Groups	712	2.164	0.815	139	2.079	0.826	23	1.652	0.714	4.83	.008
Health Planning Agencies	719	2.275	0.932	137	2.037	0.886	23	1.609	0.583	9.15	.000
Competing Organizations	714	2.129	0.899	137	1.832	0.828	24	1.958	0.955	6.62	.001

[1] Responses were scaled Major = 4; Some = 3; Little = 2; None = 1.

[2] Questionnaires sent to hospital administrators said: "State Hospital Association."

[3] Not asked of non-hospital administrators.

TABLE IV-17

DEGREE OF INFLUENCE ON DEVELOPMENT OF NEW PATIENT CARE PROGRAMS

HOSPITAL ADMINISTRATORS

	Present Influence							
	Major		Some		Little		None	
	N	%	N	%	N	%	N	%
Board	277	39.12	277	39.12	127	17.94	27	3.81
Medical Staff	467	64.06	214	29.36	44	6.04	4	.55
Administrative Staff	538	74.83	153	21.28	22	3.06	6	.83
Department Heads	288	39.94	344	47.71	82	11.37	7	.97
Patients	102	14.19	309	42.98	252	35.05	56	7.79
State Hospital Assoc.	20	2.79	184	25.66	297	41.42	216	30.13
J.C.A.H.	127	17.74	249	34.78	191	26.68	149	20.81
A.H.A.	16	2.25	157	22.05	289	40.59	250	35.11
Blue Cross/Blue Shield	40	5.62	210	29.49	263	36.94	199	27.95
Federal Government	159	22.05	270	37.45	175	24.27	117	16.23
State/Local Government	117	16.32	240	33.47	233	32.50	127	17.71
Community Interest Groups	31	4.35	211	29.63	314	44.10	156	21.91
Health Planning Agencies	80	11.13	198	27.54	281	39.08	160	22.25
Competing Hospitals	43	6.02	211	29.55	255	35.71	205	28.71

TABLE IV-18

DEGREE OF INFLUENCE ON DEVELOPMENT OF NEW PATIENT CARE PROGRAMS

LONG TERM CARE ADMINISTRATORS

	Present Influence							
	Major		Some		Little		None	
	N	%	N	%	N	%	N	%
Board	47	36.43	40	31.01	31	24.03	11	8.53
Medical Staff	56	41.79	61	45.52	13	9.70	4	2.99
Administrative Staff	108	78.26	27	19.57	2	1.45	1	.72
Department Heads	97	68.79	36	25.53	8	5.67	0	0.00
Patients	38	27.94	59	43.38	31	22.79	8	5.88
Professional Association	18	12.95	59	42.45	43	30.94	19	13.67
J.C.A.H.[1]								
A.H.A.[1]								
Blue Cross/Blue Shield	11	8.40	27	20.61	38	29.01	55	41.98
Federal Government	63	45.65	45	32.61	24	17.39	6	4.35
State/Local Government	65	47.10	42	30.43	24	17.39	7	5.07
Community Interest Groups	6	4.32	35	25.18	62	44.60	36	25.90
Health Planning Agencies	6	4.38	38	27.74	48	35.04	45	32.85
Competing Organizations	3	2.19	28	20.44	49	35.77	57	41.61

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[1] Not asked of non-hospital administrators.

TABLE IV-19

DEGREE OF INFLUENCE ON DEVELOPMENT OF NEW PATIENT CARE PROGRAMS

CLINIC ADMINISTRATORS

	Present Influence							
	Major		Some		Little		None	
	N	%	N	%	N	%	N	%
Board	22	81.48	5	18.52	0	0.00	0	0.00
Medical Staff................	20	71.43	7	25.00	1	3.57	0	0.00
Administrative Staff.........	8	29.63	14	51.85	4	14.81	1	3.70
Department Heads.............	2	8.33	10	41.67	7	29.17	5	20.83
Patients.....................	5	19.23	12	46.15	8	30.77	1	3.85
Professional Association	1	4.17	11	45.83	10	41.67	2	8.33
J.C.A.H.[1]....................								
A.H.A.[1]......................								
Blue Cross/Blue Shield.......	2	8.70	4	17.39	8	34.78	9	39.13
Federal Government...........	0	0.00	4	16.00	12	48.00	9	36.00
State/Local Government.......	0	0.00	4	16.00	11	44.00	10	40.00
Community Interest Groups....	0	0.00	3	13.04	9	39.13	11	47.83
Health Planning Agencies.....	0	0.00	1	4.35	12	52.17	10	43.48
Competing Organizations	1	4.17	7	29.17	6	25.00	10	41.67

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[1] Not asked of non-hospital administrators.

TABLE IV-20

DEGREE OF INFLUENCE ON DEVELOPMENT OF NEW PATIENT CARF PROGRAMS

HMO ADMINISTRATORS

	Present Influence							
	Major		Some		Little		None	
	N	%	N	%	N	%	N	%
Board	2	22.22	4	44.44	3	33.33	0	0.00
Medical Staff	5	55.56	3	33.33	1	11.11	0	0.00
Administrative Staff	7	77.78	2	22.22	0	0.00	0	0.00
Department Heads	3	33.33	3	33.33	3	33.33	0	0.00
Patients	2	22.22	5	55.56	1	11.11	1	11.11
Professional Association	1	11.11	2	22.22	2	22.22	4	44.44
J.C.A.H.[1]								
A.H.A.[1]								
Blue Cross/Blue Shield	1	11.11	1	11.11	1	11.11	6	66.67
Federal Government	2	25.00	3	37.50	1	12.50	2	25.00
State/Local Government	1	11.11	5	55.56	0	0.00	3	33.33
Community Interest Groups	1	11.11	2	22.22	2	22.22	4	44.44
Health Planning Agencies	0	0.00	2	22.22	2	22.22	5	55.56
Competing Organizations	2	22.22	1	11.11	2	22.22	4	44.44

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[1] Not asked of non-hospital administrators.

Patients are perceived to have the most influence in long-term care facilities, slightly less influence in clinics, and significantly less influence on hospital program development. Professional associations were seen as more influential in long-term care facilities and clinics than was the State Hospital Association for hospital administrators. This difference may be due to the question's reference to the influence on patient care program development. Questions about the Joint Commission on Accreditation of Hospitals' and the A.H.A.'s influence were only asked of hospital administrators.

No significant differences existed for the groups on the influence of Blue Cross/Blue Shield. Long-term care administrators attributed the most influence to the federal government, followed by hospital and then clinic administrators. The same pattern was true for the influence of state and local governments. Hospital administrators believed community groups had more influence on their program development with long-term care administrators expressing approximately the same extent of influence; both groups were significantly different from clinics who expressed a lower influence due to community groups. Health Planning Agencies were perceived to have the most influence by hospital administrators, then by long-term care, and clinic administrators with all differing significantly from each other. Finally, competing organizations had the most influence on hospitals, clinics, and then long-term care facilities with only the difference between hospitals and long-term care facilities being significant.

Looking at Table IV-16 in another way, role senders from within organizations such as administrative staff and medical staff are reported as having more influence on average than role senders outside the organization such as professional or community groups. Governmental groups are apparently the second most influential group at present for the hospital and long-term care administrators, although they have little impact on clinics. Health planning agencies are not rated very high on influence for any of the groups and neither are competing organizations.

In the future, a number of groups were expected to have greater influence. Table IV-21 presents the tally of those checking the column to indicate that they anticipated the particular groups would have more influence in the future. Health planning agencies and the federal government were most frequently mentioned, followed by the Board and Medical staff. By treating each person's affirmative response to the greater influence in the future question as a one and no positive response to the question as a zero, a mean score can be calculated for each role sender group within each group of administrators. Following this procedure enables the data to be tested by a one-way analysis of variance for differences in mean expected influence scores among the three groups of administrators.

Significant differences between groups exist for only two role sender groups--state/local government and health planning agencies. Hospital administrators expect health planning agencies to have more influence than do either of the other two groups. Long-term care administrators expect state/local government to have more influence in the future than do hospital administrators who, in turn, expect more influence than do clinic administrators. No other significant differences among groups existed for the role senders' future influence on patient care program development.

Role Perceptions

Role perceptions are the role occupants understanding of the sent role. Thus, role perceptions are translated into the administrator's

TABLE IV-21

NUMBER REPORTING

ROLE SENDERS EXPECTED TO HAVE GREATER INFLUENCE IN THE FUTURE ON DEVELOPMENT OF NEW PATIENT CARE PROGRAMS

	HOSPITAL ADMINISTRATORS	LONG TERM CARE ADMINISTRATORS	CLINIC ADMINISTRATORS	N
BOARD	185	25	6	218
MEDICAL STAFF	169	27	7	206
ADMINISTRATIVE STAFF	109	15	7	132
DEPARTMENT HEADS	104	17	1	123
PATIENTS	118	27	4	151
PROFESSIONAL ASSOCIATION[1]	39	12	4	55
J.C.A.H.[2]	77	-	-	77
A.H.A.[2]	30	-	-	30
BLUE CROSS/BLUE SHIELD	65	8	1	74
FEDERAL GOVERNMENT	222	47	5	276
STATE/LOCAL GOVERNMENT	148	47	2	198
COMMUNITY INTEREST GROUPS	110	21	0	131
HEALTH PLANNING AGENCIES	247	29	4	280
COMPETING ORGANIZATIONS	56	6	2	66

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[1] Questionnaires sent to hospital administrators said: "State Hospital Association."

[2] Not asked of non-hospital administrators.

evaluation of the importance or relative weights given to different facets of his role. Role perceptions were determined by asking the administrators to rate the importance of particular goals in their organizations. Table IV-22 summarizes the data from the hospital, long-term care and clinic administrators, along with the F ratios and significance probabilities from a one-way analysis of variance on the three groups.

Significant differences exist between groups for all but three of the goals/role perceptions. Clinic administrators reported a significantly lower importance for the goal, planning for expansion of patient care programs and a significantly higher score along with hospital administrators versus long-term care administrators for the goal of planning for expansion of facilities. High quality patient care is rated very important by all administrators, but the long-term care, hospital and clinic administrator groups are all statistically significantly different from each other even though the practical level of the difference is not great.

Coordination with community health care services is more important for hospital administrators than long-term care administrators, and is rated relatively low in importance for the clinic administrators. There is no significant difference between groups on their rating of the goal, recruitment and retention of professional staff. The ratings of development of harmonious interpersonal relationships among staff generated a significant difference between means, but again, the practical size of that difference is small. Cost containment was rated about the same by all three groups. Good community relationships as a goal is rated significantly lower by clinic administrators than by either of the other two groups and the same is true for good relationships with governmental agencies and for good relationships with third party payers.

TABLE IV-22

GOAL IMPORTANCE/ROLE PERCEPTIONS[1]

	HOSPITAL ADMINISTRATORS			LONG-TERM CARE ADMINISTRATORS			CLINIC ADMINISTRATORS				
	N	MEAN	S.D.	N	MEAN	S.D.	N	MEAN	S.D.	F RATIO	SIGNIFICANCE PROBABILITY
TOTAL N	755			148			31				
Planning for Expansion of [Hospital][2] Patient Care Programs	716	79.01	23.10	140	79.31	24.15	30	68.07	25.54	3.22	.040
Planning for Expansion of [Hospital][2] Facilities	719	65.25	31.55	141	46.67	34.15	30	69.27	27.91	20.75	.000
High Quality Patient Care	735	96.42	6.852	145	97.94	4.367	30	89.73	15.263	17.31	.000
Coordination with Community Health Care Services	718	71.46	21.31	136	67.05	23.94	30	44.00	23.17	24.18	.000
Recruitment and Retention of Professional Staff	731	84.39	17.71	146	86.05	14.83	30	80.23	24.42	1.47	.230
Development of Harmonious Interpersonal Relationships Among Staff	733	83.66	17.869	146	88.95	12.441	29	84.28	16.219	5.84	.003
Cost Containment	731	85.13	15.71	143	86.57	13.72	30	81.80	19.47	1.28	.279
Good Community Relationships	734	84.62	16.14	146	81.29	19.19	29	71.48	22.81	10.14	.000
Good Relationships with Governmental Agencies	732	70.75	23.64	146	76.48	22.43	30	46.03	24.70	20.95	.000
Good Relationships With Third Party Payers	726	70.54	24.35	144	73.25	24.85	30	51.00	23.80	10.46	.000
Teaching	719	58.20	29.28	143	64.94	25.82	29	23.93	24.29	24.76	.000
Research	716	23.93	27.35	141	36.91	28.57	29	17.24	20.34	14.71	.000
Shared Services with Other [Hospitals][3]	731	54.69	27.69	143	44.58	30.55	28	30.32	29.16	16.49	.000
Planned Improvement of Administrative Services	714	70.09	22.795	143	70.03	23.473	29	69.83	24.967	.00	.958

[1] Responses were scaled: 100 = Very Important; 50 = Moderately Important; 0 = Not Important; intermediate scale points were also available for responses although not labeled.

[2] The word hospital was used only in questionnaires to hospital administrators.

[3] The term "health care providers" replaced the word "hospitals" in questions to long-term care, clinic, and HMO administrators.

Teaching and research as goals are rated highest by long-term care administrators, second highest by hospital administrators, and lowest by clinic administrators. Both of these goals have significantly different means between groups, and in addition, are rated on the whole as being less important than the other goals. Shared services as a goal was given a relatively low importance and again showed a significant difference between groups. Planned improvement of administrative services received approximately the same score across all three groups.

Quality patient care appears to be an important goal for all three groups of administrators as do staff related goals such as recruitment and retention and the development of harmonious relationships. Cost containment and good community relationships also appear among the five most highly rated goals based on the mean scores for all three groups of administrators. Near the bottom of each group's list, based on mean scores, are goals related to teaching, research, and shared services.

Role Performance Behaviors

Role performance behaviors involve the tasks, activities, and roles which administrators engage in as they fulfill their organizational roles. All long-term care and clinic administrators and two of the three subsets of hospital administrators responded to task and role description questions. The use of the multiple questionnaire forms is further described in Appendix A and the multiple forms are reproduced in Appendix B. Managerial role descriptions, tasks, and managerial activities responses for hospital administrators were discussed in Chapter II on pages 41 through 55, and in Tables II-6 and II-8. Parallel tables for long-term care administrators are Tables IV-23 and IV-28 and for clinic administrators IV-24 and IV-29.

The data described in this section are based on the 148 long-term care facility administrators and 31 clinic managers, as well as 275 hospital administrators who responded to the managerial roles questions and the 174 hospital administrators who responded to the task activities questions. Thus, long-term care administrators and clinic administrators refer to the same individuals in all reported results, while hospital administrators refer to one group in discussing managerial roles, and to a second group when discussion task activities.

Managerial Role Descriptions

Table IV-23 presents the mean scores and rankings for the long-term care administrators' ratings of time consumed, importance, and anticipated importance of the managerial roles. The scores are arranged in rank order based on the time consumed column's mean scores. Responses in the average category were coded as a "3" while most time consumed (importance, anticipated importance) was coded as a "5" and least time consumed (importance, anticipated importance) was coded as a "1." Thus, a mean score above 3 indicates above average time consumed, importance, or anticipated importance, while a mean score below 3 means that the role was considered to be below average. Role definitions appear in Table II-1 on page 24.

As described for hospital administrators in Chapter II, the Leader and Entrepreneur roles rank first and second and Table IV-23 also shows that the Monitor and Resource Allocator roles are third and fourth across all three columns for the long-term care administrators. In fact, only one change in rankings exists between the time consumed and importance columns with the Disseminator and Negotiator roles exchanging positions. Further changes do occur between the importance and anticipated importance columns in the six lower ranked roles. The Disturbance-Handler role decreases

TABLE IV-23

MANAGERIAL ROLE DESCRIPTIONS
LONG-TERM CARE ADMINISTRATORS*

ROLE	TIME CONSUMED		IMPORTANCE		ANTICIPATED IMPORTANCE	
	MEAN	RANK	MEAN	RANK	MEAN	RANK
The Leader	4.172	1	4.299	1	3.831	1
The Entrepreneur	3.742	2	3.778	2	3.711	2
The Monitor	3.353	3	3.363	3	3.292	3
The Resource Allocator	3.281	4	3.258	4	3.235	4
The Disturbance Handler	3.000	5	3.016	5	2.896	7
The Liaison	2.775	6	2.864	6	3.033	5
The Disseminator	2.704	7	2.573	8	2.504	9
The Negotiator	2.566	8	2.624	7	2.959	6
The Spokesman	2.527	9	2.388	9	2.636	8
The Figurehead	1.923	10	1.992	10	1.975	10

*Responses were scaled: 1 = Least (Time Consumed, Importance, Anticipated Importance); 2 = Below Average (Time Consumed, Importance, Anticipated Importance); 3 = Average (Time Consumed, Importance, Anticipated Importance); 4 = Above Average (Time Consumed, Importance, Anticipated Importance); and 5 = Most (Time Consumed, Importance, Anticipated Importance).

in mean score and ranking as does the Disseminator role for the anticipated importance column. The Liaison, Negotiator, and Spokesman roles increase in mean scores and in their ranking.

Long-term care administrators currently perceive their managerial role to principally involve interpersonal relationships and motivation of subordinates, change initiation for their organization, information gathering, and allocation of resources. One role is included from the interpersonal roles group, one from the informational roles group, and two from the decisional roles group. It is significant that the long-term care administrators rank the top four roles in the same order for time consumed, importance, and anticipated importance. Changes are expected in the anticipated importance of only lower ranked roles. This finding conforms with the data of Table IV-15 which indicates that only 50% of the long-term care administrators felt their role would change.

Table IV-24 presents the mean scores and rankings for the clinic administrators' ratings of the managerial roles. Again, the roles are arranged in rank order based on the time consumed column's mean scores.

For clinic administrators, the roles fall into three groups with movement within but not between those groups in the roles' rankings. The Leader, Monitor, Entrepreneur, and Negotiator roles are the first group with the four roles ranked consistently among the top four. The Resource Allocator, Disturbance Handler, Disseminator, and Liaison roles rank between fifth and eighth consistently and comprise the second group. The Spokesman and Figurehead roles consistently rank ninth and tenth respectively across the time, importance, and anticipated importance columns.

Between the time consumed and importance columns, the only shift in rank of more than one position is for the Liaison role which scores and ranks

TABLE IV-24

MANAGERIAL ROLE DESCRIPTIONS
CLINIC ADMINISTRATORS*

ROLE	TIME CONSUMED		IMPORTANCE		ANTICIPATED IMPORTANCE	
	MEAN	RANK	MEAN	RANK	MEAN	RANK
The Leader	4.100	1	4.074	1	3.600	2
The Monitor	3.690	2	3.654	3	3.417	4
The Entrepreneur	3.571	3	3.760	2	3.917	1
The Negotiator	3.250	4	3.074	4	3.462	3
The Resource Allocator	3.107	5	3.038	5.5	3.000	6
The Disturbance Handler	3.100	6	2.920	7	2.920	7
The Disseminator	2.741	7	2.720	8	2.520	8
The Liaison	2.467	8	3.038	5.5	3.208	5
The Spokesman	2.259	9	2.200	9	2.480	9
The Figurehead	1.821	10	1.480	10	1.680	10

*Responses were scaled: 1 = Least (Time Consumed, Importance, Anticipated Importance); 2 = Below Average (Time Consumed, Importance, Anticipated Importance); 3 = Average (Time Consumed, Importance, Anticipated Importance); 4 = Above Average (Time Consumed, Importance, Anticipated Importance); and 5 = Most (Time Consumed, Importance, Anticipated Importance).

higher in the importance column than it does in the time consumed column, thus suggesting that the clinic administrator perceives the external liaison role to be more important than the time which it consumes. Between the Importance and Anticipated Importance columns, a number of changes occur; however, most of them again represent movement from one rank to an adjacent one. Perhaps most interesting is that, on average, the clinic administrators expect the Entrepreneur role to be most important in the future.

Clinic administrators currently perceive their managerial role to principally involve a combination of interpersonal relationships and motivation of subordinates, change initiation for the organization, information gathering, and negotiation with outside parties. The components of their role in the future will be similar with special emphasis upon change initiation and motivation and interpersonal relations with subordinates. Again, substantial changes in role are not foreseen which conforms with the data of Table IV-15 on role change expectations.

Tables IV-25, IV-26, and IV-27, respectively, present the mean scores for the three groups of administrators' ratings of time consumed, importance, and anticipated importance of the managerial roles. The roles are arranged in rank order, based on the hospital administrators' mean scores. The rank order of all groups' scores are shown in the table with the means. The F Ratios from a one-way analysis of variance on the three groups and the associated significance probabilities are also shown. These tables contrast the differences across institutions for the questions on managerial roles.

Table IV-25 summarizes the mean scores for the time consumed in the various roles. The Leader, Entrepreneur, and Monitor roles ranked among the first three for all groups, with minor but non-significant differences between mean scores. Thus, among the three most time-consuming roles, was one from each of Mintzberg's categories of interpersonal, informational, and decisional roles as classified in Table II-1. Significant differences between the groups

TABLE IV-25

MANAGERIAL ROLE DESCRIPTIONS
TIME CONSUMED

Role	Hospital Administrators Mean	Hospital Administrators Rank	Long-Term Care Administrators Mean	Long-Term Care Administrators Rank	Clinic Administrators Mean	Clinic Administrators Rank	F Ratio	Significance Probability
The Leader	3.960	1	4.172	1	4.100	1	2.20	.112
The Entrepreneur	3.780	2	3.742	2	3.571	3	.63	.534
The Monitor	3.455	3	3.353	3	3.690	2	1.92	.148
The Resource Allocator	3.331	4	3.281	4	3.107	5	.89	.413
The Liaison	2.845	5	2.775	6	2.467	8	1.75	.175
The Negotiator	2.774	6	2.566	8	3.250	4	5.45	.005**
The Disseminator	2.692	7	2.704	7	2.741	7	.05	.953
The Disturbance Handler	2.674	8	3.000	5	3.100	6	7.06	.001**
The Spokesman	2.631	9	2.527	9	2.259	9	2.64	.073
The Figurehead	1.869	10	1.923	10	1.821	10	.18	.838

Responses were scaled: 1 = Least (Time Consumed, Importance, Anticipated Importance); 2 = Below Average (Time Consumed, Importance, Anticipated Importance); 3 = Average (Time Consumed, Importance, Anticipated Importance); 4 = Above Average (Time Consumed, Importance, Anticipated Importance); and 5 = Most (Time Consumed, Importance, Anticipated Importance).

* .05 level of significance.

** .01 level of significance.

of executives existed only for the Negotiator role, with clinic executives considering the role significantly more time consuming, and for the Disturbance Handler role with hospital executives considering this role significantly less time consuming than either clinic or long-term care facility executives.

Table IV-26 summarizes the mean scores for the importance of the various roles. Again, the Entrepreneur, Leader, and Monitor roles ranked among the three most important roles for all groups. Thus, the executives seemed to indicate a congruence between the importance of the various roles and the time that they spend fulfilling them. There were minor differences between the groups for the Entrepreneur and Monitor roles, but a significant difference between the groups--and in particular between the hospital administrators and the long-term care executives for the Leader role. The long-term care executives rated the importance of the Leader role higher than either of the other groups, suggesting that this role of interpersonal relationships and motivation is more crucial in the long-term care facility than it is in the hospital. There were a number of other significant and interesting differences between the groups on the Negotiator, Spokesman, Disturbance Handler, and Figurehead roles. The Negotiator role was reported as significantly less important in long-term care facilities than in the other two settings. The Spokesman role was significantly more important to the hospital administrators than to either of the other two groups. The hospital administrators further reported on average that the Disturbance Handler role is less important in their settings than in long-term care facilities or clinics. Finally, clinic administrators assigned a significantly lower importance to the Figurehead role than do either hospital administrators or long-term care facility administrators.

Table IV-27 summarizes the mean scores for the anticipated importance

TABLE IV-26

MANAGERIAL ROLE DESCRIPTIONS
IMPORTANCE

Role	Hospital Administrators		Long-Term Care Administrators		Clinic Administrators		F Ratio	Significance Probability
	Mean	Rank	Mean	Rank	Mean	Rank		
The Entrepreneur	3.951	1	3.778	2	3.760	2	1.59	.206
The Leader	3.942	2	4.299	1	4.074	1	6.37	.002**
The Monitor	3.331	3	3.363	3	3.654	3	1.90	.152
The Resource Allocator	3.275	4	3.258	4	3.038	5.5	.86	.424
The Liaison	3.137	5	2.864	6	3.038	5.5	2.92	.055
The Negotiator	2.900	6	2.624	7	3.074	4	4.70	.010**
The Spokesman	2.675	7	2.388	9	2.200	9	7.46	.001**
The Disturbance Handler	2.610	8	3.016	5	2.920	7	9.21	.000**
The Disseminator	2.525	9	2.573	8	2.720	8	.68	.508
The Figurehead	1.751	10	1.992	10	1.480	10	3.72	.025*

Responses were scaled: 1 = Least (Time Consumed, Importance, Anticipated Importance); 2 = Below Average (Time Consumed, Importance, Anticipated Importance); 3 = Average (Time Consumed, Importance, Anticipated Importance); 4 = Above Average (Time Consumed, Importance, Anticipated Importance); and 5 = Most (Time Consumed, Importance, Anticipated Importance).

* .05 level of significance.
** .01 level of significance.

of the various roles. The Entrepreneur and Leader roles again appeared in the first and second rank positions for all three groups of administrators. As Table IV-27 indicates, however, there were a number of shifts in ranking between hospital administrators and the long-term care and clinic administrators for the anticipated importance of the next four roles. The Monitor role declined to rank six in anticipated importance, while it maintained a third rank for the long-term care administrators and a fourth rank for the clinic administrators. Hospital administrators perceived the Liaison role, another interpersonal role, to be the third most important role which they will play in the future. This is a significant difference from the perception of anticipated importance for this role for the other administrators. The Negotiator role appeared to increase in importance for the clinic administrators in the future. Hospital executives also perceived in the future that they will be playing more of the spokesman role for their institution, while clinic and long-term care executives showed a significant difference versus hospital executives for the Disturbance Handler role.

In summary, then, the questionnaire responses suggest a number of conclusions about managerial roles in the three types of institutions. Regarding the time consumed, more direct negotiations by clinic managers appears to occur. In addition, they more frequently play the Disturbance Handler role versus their hospital colleagues. Both of these roles may be a function of the flatter organizational structure of clinics, and in essence, of their smaller size.

Regarding the importance of the various roles, we might speculate that the institutionalization of the hospital leads to the lower importance of the Leader role as here defined and of the Disturbance Handler role for the chief executive himself. The importance of the Spokesman role for the hospital chief executive is another reflection of the hospital executive's

TABLE IV-27

MANAGERIAL ROLE DESCRIPTIONS
ANTICIPATED IMPORTANCE

Role	Hospital Administrators		Long-Term Care Administrators		Clinic Administrators		F Ratio	Significance Probability
	Mean	Rank	Mean	Rank	Mean	Rank		
The Entrepreneur	3.689	1	3.711	2	3.917	1	.52	.593
The Leader	3.597	2	3.831	1	3.600	2	2.20	.112
The Liaison	3.453	3	3.033	5	3.208	5	6.23	.002**
The Negotiator	3.240	4	2.959	6	3.462	3	3.79	.023*
The Resource Allocator	3.189	5	3.235	4	3.000	6	.60	.548
The Monitor	3.156	6	3.292	3	3.417	4	1.85	.159
The Spokesman	2.921	7	2.636	8	2.480	9	5.89	.003**
The Disturbance Handler	2.587	8	2.896	7	2.920	7	5.32	.005**
The Disseminator	2.478	9	2.504	9	2.520	8	.07	.934
The Figurehead	1.809	10	1.975	10	1.680	10	1.22	.298

Responses were scaled: 1 = Least (Time Consumed, Importance, Anticipated Importance); 2 = Below Average (Time Consumed, Importance, Anticipated Importance); 3 = Average (Time Consumed, Importance, Anticipated Importance); 4 = Above Average (Time Consumed, Importance, Anticipated Importance); and 5 = Most (Time Consumed, Importance, Anticipated Importance).

* .05 level of significance.
** .01 level of significance.

need to be the external representative of his institution as further reported in Chapter V on the interview phase of the project. Finally, the low importance rating given to the Figurehead role by clinic administrators may be an indication that they essentially are background people, rather than pro-active and visible representatives of their institutions.

The anticipated importance of the various roles in the next three to five years provides a number of insights into anticipated changes in the institutional settings as well as in the roles of the chief executive officers. The increased importance of the Liaison role, and the continued significantly greater importance of the Spokesman role for hospital chief executives again confirms the development of the chief executive as the external institutional representative, which in turn, implies a decrease in his daily operational activities, resulting in more delegation.

It is interesting to note that in terms of time consumed, the various roles do not differ very much across institutions. However, in terms of their importance and anticipated importance, there are a number of significant differences in the roles across institutions. Overall, however, it appears that the three groups of health delivery executives perceive their roles to be quite similar. This similarity of roles across institutions suggests the possibility of similar developmental programs and of transferability of executives from one institution to another.

Managerial Task Activities

Tables IV-28 and IV-29 present data about the managerial task activities form of the questionnaire. The two major columns summarize those tasks which the administrators most frequently perform themselves and those tasks which they reported were delegated to others in their organizations. The ranks of the tasks in each column are also shown. For long-term care administrators, six of the 47 tasks were checked by more than five percent of the administrators in the "Not Performed by Personnel in the Organization" column. These six tasks were:

"Negotiate labor union contracts," 42.54%;

"Negotiate financial agreements (insurance and facilities)," 6.85%;

"Negotiate reimbursement rates with third party payers," 13.10%;

"Recommend to the board the rates to be charged for services," 6.16%;

"Advise the Board of Trustees on matters requiring policy formulation," 7.04%; and,

"Write articles for professional journals of benefit to other administrators," 55.07%.

For clinic administrators, 18 of the 47 tasks were checked by more than five percent of the administrators in the "Not Performed by Personnel in the Organization" column. These 18 tasks were:

"Appoint administrative personnel," 6.90%;

"Develop personnel recruiting methods," 10.00%;

"Negotiate labor union contracts," 76.92%;

"Direct and coordinate activities of nursing services," 6.67%;

"Interpret changes in rules and regulations (governmental policies, for example) to organizational employees," 10.00%;

"Negotiate reimbursement rates with third party payers," 17.24%;

"Prepare operations budget," 10.00%;

"Review and revise budget allocations," 10.00%;

"Represent organization on commissions, agencies, or at hearings," 13.33%;

"Communicate health care needs to persons external to the organization," 13.33%;

"Represent the organization in its relationships to other health agencies," 6.67%;

"Develop a long-range planning program for the organization," 10.00%;

"Coordinate safety programs," 10.00%;

"Formulate health care policies," 6.67%;

"Organize health care services," 10.00%;

"Plan and determine health care quality standards," 6.67%;

"Meet regulatory and accreditation requirements," 13.33%; and,

"Write articles for professional journals of benefit to other administrators," 55.17%.

The six "Not Performed" tasks are marked with an asterisk in Table IV-28, while the 18 are marked with an asterisk in Table IV-29.

Table IV-28 summarizes the distribution of tasks data from the long-term care administrators. This table is similar to Table II-8 for hospital administrators on page 49 with the related discussion on pages 48 through 54. For the nine tasks reported as being performed directly by 75% or more of the long-term care executives, there appear to be three major categories of activities, just as there were for the hospital administrators.

Policy matters, including advising the Board of Trustees and recommending rates, external affairs, including representation of the organization, and internal management activities occupy the executives' time. Internal management includes appointing administrative personnel and department heads, approving their promotions and transfers, meeting regulatory requirements and interpreting changes in regulations. On the whole, the activities reported by the long-term care executives are similar to those reported by the hospital respondents, with perhaps a slightly more operational tone for the long-term care respondents who, for example, among their highest ranked tasks, interpret rules and regulations versus keeping informed of legal changes for the hospital administrators.

TABLE IV-28

DISTRIBUTION OF TASKS
LONG-TERM CARE ADMINISTRATORS

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Appoint department heads.	90.34	1	8.97	46
Advise the Board of Trustees on matters requiring policy formulation.*	84.51	2	8.45	47
Meet regulatory and accreditation requirements.	81.25	3	18.75	39
Appoint administrative personnel.	80.69	5	14.48	43
Approve promotions and transfers of department heads.	80.69	5	17.24	42
Represent the organization in its relationships to other health agencies.	80.69	5	18.62	40
Represent organization on commissions, agencies, or at hearings.	79.02	7	18.18	41
Recommend to the board the rates to be charged for services.*	78.77	8	15.07	44
Interpret changes in rules and regulations (governmental policies, for example) to organizational employees.	75.34	9	23.29	38
Analyze expenditures.	74.66	10	24.66	36.5
Interpret policies, procedures, and regulations.	73.97	11	24.66	36.5
Keep informed of legal changes affecting the organization.	72.41	12	26.21	35
Evaluate managerial performance.	72.03	13	27.97	31
Review and revise budget allocations.	69.86	14	27.40	33

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Allocate organizational resources to achieve organizational goals.	68.97	15.5	28.28	30
Prepare administrative reports.	68.97	15.5	29.66	29
Develop a long-range planning program for the organization.	68.28	17	27.59	32
Search the organization and its environment for more efficient operations.	66.21	18	33.10	27
Conduct studies of financial performance and recommend changes.	64.14	19	31.03	28
Approve purchases of expensive equipment.	63.01	20.5	33.56	26
Formulate wage and salary pay plans.	63.01	20.5	34.93	25
Solve cash flow problems.	58.22	22	39.04	24
Establish procedures for preparing and submitting reports.	58.04	23	40.46	22
Prepare operations budget.	56.16	24	41.10	20.5
Communicate health care needs to persons external to the organization.	56.03	25	39.72	23
Formulate personnel policies.	55.48	26	41.10	20.5
Enforce administrative policies and operating procedures.	53.79	27	46.21	16
Assist medical staff with its organizational and medical-administrative problems and responsibilities.	52.48	28	43.97	19
Negotiate financial agreements (insurance and facilities).*	47.95	29	45.21	18
Investigate patient/resident complaints.	47.59	30	52.41	15

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Plan and determine manpower requirements.	45.14	31	54.86	13
Plan and determine health care quality standards.	42.47	32	54.79	14
Negotiate reimbursement rates with third party payers.*	41.38	33.5	45.52	17
Formulate health care policies	41.38	33.5	57.24	12
Plan administrative office practices and procedures.	40.69	35.5	57.93	11
Resolve employee complaints and grievances.	40.69	35.5	59.31	10
Organize health care services.	36.36	37	62.94	9
Contract for purchase and delivery of supplies and services.	32.19	38	65.75	8
Write articles for professional journals of benefit to other administrators.*	31.88	39	13.04	45
Negotiate labor union contracts.*	30.60	40	26.87	34
Coordinate personnel programs.	30.56	41	68.75	7
Coordinate maintenance and repair activities.	29.55	42	70.45	6
Coordinate safety programs.	25.34	43	74.66	5
Evaluate training programs.	23.08	44	75.52	4
Develop personnel recruiting methods.	21.68	45	77.62	3
Direct and coordinate activities of nursing services.	4.90	46	95.10	2
Direct personnel training programs.	2.13	47	97.87	1

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[1] This column shows the percentage of respondents who answered the question by checking the column headed "Performed Directly." The column heading was further explained by the statement, "This activity is a primary duty of mine and is usually performed directly by me."

[2] This column shows the combined percentage of respondents who answered the questions by checking either of the two columns headed "Accomplished Indirectly" or "Performed by Others." These column headings were further explained by the statements, "This activity is a responsibility of mine, but is usually accomplished indirectly by my delegating it to others," and "This activity is not a direct responsibility of mine, but is performed by other individuals in the organization."

*More than 5% responded by checking the "Not Performed by Personnel in the Organization" column.

From the other direction, for those tasks most clearly not regularly carried out by the administrators, the tasks performed directly by less than 25% of the long-term care administrators include only four. Three of these tasks are related to basic personnel tasks such as training and recruiting (ranks 44, 45, 47) and one is related to the coordination of nursing services. Again, these results are quite similar to those reported in Table II-8 for the hospital administrators.

Table IV-29 summarizes the distribution of tasks data from the clinic administrators. This table is also similar to Table II-8 for the hospital administrators. For the nine tasks reported as being performed directly by 75% or more of the clinic administrators, some of the same tasks again are present.

Management of senior level personnel includes three tasks; advice on policy and legal awareness of external matters each represent one task. Four tasks are concerned with financial management: solve cash flow problems; negotiate financial agreements; conduct studies of financial performance; and analyze expenditures. The other two groups of administrators do not place such a strong emphasis on financial affairs in the tasks which they perform directly; thus, clearly suggesting that there are some distinctive features to the clinic administrator job versus the hospital or long-term care administrator job.

Among those tasks performed directly by less than 25% of the clinic administrators, the same type of tasks appear as they did for the long-term care and hospital administrators. Activities related to basic personnel issues (such as negotiating labor union contracts or directing personnel programs), to patient care (such as investigating complaints, organizing services, coordinating nursing services, and determining quality standards), and to safety programs are all not engaged in by the clinic administrators.

TABLE IV-29

DISTRIBUTION OF TASKS
CLINIC ADMINISTRATORS

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Keep informed of legal changes affecting the organization.	90.00	1	10.00	45
Solve cash flow problems.	86.67	2.5	13.33	43.5
Advise the Board of Trustees on matters requiring policy formulation.	86.67	2.5	13.33	43.5
Negotiate financial agreements (insurance and facilities).	83.33	4	16.67	41
Conduct studies of financial performance and recommend changes.	80.00	5	20.00	37.5
Approve promotions and transfers of department heads.	79.31	6.5	17.24	40
Appoint administrative personnel.*	79.31	6.5	13.79	42
Appoint department heads.	76.67	8.5	23.33	34.5
Analyze expenditures.	76.67	8.5	23.33	34.5
Formulate wage and salary pay plans.	73.33	10.5	26.67	30.5
Recommend to the Board the rates to be charged for services.	73.33	10.5	23.33	34.5
Evaluate managerial performance.	72.41	12	24.14	32
Develop a long-range planning program for the organization.*	70.00	13	20.00	38
Interpret policies, procedures, and regulations.	66.67	14.5	33.33	28
Represent organization on commissions, agencies, or at hearings.*	66.67	14.5	20.00	38

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Formulate personnel policies.	65.52	16.5	34.48	26.5
Assist medical staff with its organizational and medical-administrative problems and responsibilities.	65.52	16.5	34.48	26.5
Coordinate maintenance and repair activities.	64.29	18	35.71	25
Establish procedures for preparing and submitting reports.	63.33	20	36.67	23
Meet regulatory and accreditation requirements.*	63.33	20	23.33	34.5
Prepare operations budget.*	63.33	20	26.67	30.5
Plan and determine manpower requirements.	60.00	23	40.00	19
Review and revise budget allocations.*	60.00	23	30.00	29
Prepare administrative reports.	60.00	23	40.00	19
Search the organization and its environment for more efficient operations.	58.62	25	41.38	17
Represent the organization in its relationships to other health agencies.*	56.67	26.5	36.67	23
Allocate organizational resources to achieve organizational goals.	56.67	26.5	40.00	19
Enforce administrative policies and operating procedures.	53.33	29	46.67	15
Approve purchases of expensive equipment.	53.33	29	43.33	16
Interpret changes in rules and regulations (governmental policies, for example) to organizational employees.*	53.33	29	36.67	23
Evaluate training programs.	48.28	31	48.28	14

TASK	% PERFORMING TASK DIRECTLY[1]		% DELEGATING TASK TO OTHERS IN ORGANIZATION[2]	
	%	RANK	%	RANK
Negotiate reimbursement rates with third party payers.*	44.83	32	37.93	21
Contract for purchase and delivery of supplies and services.	40.00	33.5	60.00	11
Develop personnel recruiting methods.*	40.00	33.5	50.00	13
Coordinate personnel programs.	37.93	35.5	62.07	10
Write articles for professional journals of benefit to other administrators.*	37.93	35.5	6.90	46
Plan administrative office practices and procedures.	36.67	37.5	63.33	8.5
Resolve employee complaints and grievances.	36.67	37.5	63.33	8.5
Communicate health care needs to persons external to the organization.*	33.33	39	53.33	12
Formulate health care policies.*	26.67	40	66.67	6.5
Investigate patient/resident complaints.	23.33	41.5	76.67	4
Organize health care services.*	23.33	41.5	66.67	6.5
Negotiate labor union contracts.*	23.08	43	0.00	47
Coordinate safety programs.*	16.67	44	73.33	5
Direct personnel training programs.	13.33	45	83.33	2.5
Plan and determine health care quality standards.*	10.00	46	83.33	2.5
Direct and coordinate activities of nursing services.*	6.67	47	86.67	1

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[1] This column shows the percentage of respondents who answered the question by checking the column headed "Performed Directly." The column heading was further explained by the statement, "This activity is a primary duty of mine and is usually performed directly by me."

[2] This column shows the combined percentage of respondents who answered the questions by checking either of the two columns headed "Accomplished Indirectly" or "Performed by Others." These column headings were further explained by the statements, "This activity is a responsibility of mine, but is usually accomplished indirectly by my delegating it to others," and "This activity is not a direct responsibility of mine, but is performed by other individuals in the organization."

*More than 5% responded by checking the "Not Performed by Personnel in the Organization" column.

Table IV-30 provides a listing of the tasks with the associated percentage of administrators performing it directly and their ranks for each of the three groups of administrators. The table is rank ordered based on the hospital administrators' column. Thus, the table enables comparisons of percentages and ranks across the three administrator groups for each task.

Of the 11 tasks performed directly by 70% or more of the hospital administrators, seven are also in the top 11 ranking for long-term care administrators, while six are in the top 11 ranking for clinic administrators. Advising the board of trustees, appointing administrative personnel, appointing department heads, approving promotions and transfers of department heads, and recommending rates for services to the board are common to all groups. Representational activities are common in the top ranked tasks for hospital and long-term care administrators while keeping informed of legal changes is within the top 11 tasks for hospital and clinic administrators and ranks twelfth for long-term care administrators. Interestingly enough, assisting the medical staff with its organizational and medical-administrative problems and responsibilities is most highly ranked by hospital administrators, and ranked less strongly as an activity performed directly by long-term care and clinic administrators. Long-term care administrators, of course, often do not have an affiliated medical staff.

The clinic managers also reported less often representing the organization on commissions, agencies, or at hearings, or in its general relationships with other agencies. Presumably, in clinics, the medical staff itself plays the representative role for the agency at least in the perception of many of these respondents. Long-range planning is most highly ranked for the hospital administrators although it is performed directly by high percentages of the other administrators.

TABLE IV-30

DISTRIBUTION OF TASKS
% PERFORMING TASK DIRECTLY[1]

TASK	HOSPITAL ADMINISTRATORS		LONG-TERM CARE ADMINISTRATORS		CLINIC ADMINISTRATORS	
	%	RANK	%	RANK	%	RANK
Advise the board of trustees on matters requiring policy formulation.	93.45	1	84.51	2	86.67	2.5
Appoint administrative personnel.	91.23	2	80.69	5	79.31	6.5
Assist medical staff with its organizational & medical-administrative problems and responsibilities.	84.52	3	52.48	28	65.52	16.5
Represent organization on commissions, agencies, or at hearings.	82.84	4	79.02	7	66.67	14.5
Represent the organization in its relationships to other health agencies.	77.65	5	80.69	5	56.67	26.5
Develop a long-range planning program for the organization.	77.51	6	68.28	17	70.00	13
Keep informed of legal changes affecting the organization.	76.92	7	72.41	12	90.00	1
Approve purchases of expensive equipment.	76.47	8	63.01	20.5	53.33	29
Appoint department heads.	76.02	9	90.34	1	76.67	8.5

TASK	HOSPITAL ADMINISTRATORS		LONG-TERM CARE ADMINISTRATORS		CLINIC ADMINISTRATORS	
	%	RANK	%	RANK	%	RANK
Approve promotions & transfers of department heads.	75.15	10	80.69	5	79.31	6.5
Recommend to the board the rates to be charged for services.	73.65	11	78.77	8	73.33	10.5
Allocate organizational resources to achieve organizational goals.	68.86	12	68.97	15.5	56.67	26.5
Evaluate managerial performance.	67.65	13	72.03	13	72.41	12
Communicate health care needs to persons external to the organization.	65.66	14	56.03	25	33.33	39
Interpret policies, procedures, and regulations.	62.13	15	73.97	11	66.67	14.5
Meet regulatory and accreditation requirements.	62.05	16	81.25	3	63.33	20
Prepare administrative reports.	55.88	17	68.97	15.5	60.00	23
Interpret changes in rules and regulations (governmental policies, for example) to organizational employees.	46.20	18	75.34	9	53.33	29
Negotiate financial agreements (insurance and facilities).	45.88	19	47.95	29	83.33	4
Review and revise budget allocations.	45.83	20	69.86	14	60.00	23
Establish procedures for preparing and submitting reports.	44.12	21	58.04	23	63.33	20

TASK	HOSPITAL ADMINISTRATORS		LONG-TERM CARE ADMINISTRATORS		CLINIC ADMINISTRATORS	
	%	RANK	%	RANK	%	RANK
Formulate wage and salary pay plans.	40.00	22.5	63.01	20.5	73.33	10.5
Write articles for professional journals of benefit to other administrators.	40.00	22.5	31.88	39	37.93	35.5
Analyze expenditures.	37.87	24	74.66	10	76.67	8.5
Search the organization and its environment for more efficient operations.	37.72	25	66.21	18	58.62	25
Formulate Personnel policies.	34.94	26	55.48	26	65.52	16.5
Plan and determine manpower requirements.	34.12	27	45.14	31	60.00	23
Solve cash flow problems.	32.93	28	58.22	22	86.67	2.5
Enforce administrative policies and operating procedures.	32.74	29	53.79	27	53.33	29
Plan administrative office practices and procedures.	27.06	30	40.69	35.5	36.67	37.5
Negotiate reimbursement rates with third party payers.	26.19	31	41.38	33.5	44.83	32
Conduct studies of financial performance and recommend changes.	26.04	32	64.14	19	80.00	5
Investigate patient/resident complaints.	25.44	33	47.59	30	23.33	41.5
Resolve employee complaints and grievances.	23.21	34	40.69	35.5	36.67	37.5

TASK	HOSPITAL ADMINISTRATORS		LONG-TERM CARE ADMINISTRATORS		CLINIC ADMINISTRATORS	
	%	RANK	%	RANK	%	RANK
Prepare operations budget.	20.71	35	56.16	24	63.33	20
Evaluate training programs.	19.76	36	23.08	44	48.28	31
Coordinate personnel programs.	19.30	37	30.56	41	37.93	35.5
Negotiate labor union contracts.	17.31	38	30.60	40	23.08	43
Plan and determine health care quality standards.	15.06	39	42.47	32	10.00	46
Develop personnel recruiting methods.	14.62	40	21.68	45	40.00	33.5
Organize health care services.	8.93	41	36.36	37	23.33	41.5
Contract for purchase and delivery of supplies and services.	7.74	42	32.19	38	40.00	33.5
Formulate patient care policies.	7.19	43	41.38	33.5	26.67	40
Coordinate safety programs.	5.99	44	25.34	43	16.67	44
Coordinate maintenance and repair activities.	4.73	45	29.55	42	64.29	18
Direct and coordinate activities of nursing services.	4.14	46	4.90	46	6.67	47
Direct personnel training programs.	2.35	47	2.13	47	13.33	45

[1] This table shows the percentage of respondents who answered the question by checking the column headed "Performed Directly." The column heading was further explained by the statement, "This activity is a primary duty of mine and is usually performed directly by me."

Table IV-31 summarizes the data from the questionnaire which reflects the tasks which administrators regularly delegate. Again, the table is rank ordered based on the hospital administrators' column. Activities related to the provision of patient care and to basic personnel programs clearly predominate in these delegated tasks. Maintenance, safety, and purchasing also appear high on these lists. If any overall characterization of the most delegated tasks is appropriate, perhaps it is fair to say that routinization is a common element in them. Distinguishing among those tasks which are often delegated and those which are often performed directly is one step in delineating the role of these administrators; further clarification of the many tasks which fall into the middle range is still needed.

As noted in Chapter II, there is considerable overlap between the roles and task activities data, each reinforcing and confirming the other. The roles data reflect the importance of interpersonal relations and motivation, and the task data emphasizes that this particularly involves senior level personnel. The initiation of change role is paralleled by the policy-related tasks; and the information gathering role clearly relates to external representation. Even for the clinic administrators with their heavy emphasis on financial tasks, the Negotiator role is somewhat parallel in importance.

If the roles data are assessed in terms of their future implications for tasks performed directly by chief executives, it seems likely that the representational and senior personnel management tasks will expand as will the policy-oriented responses to change. Clinic personnel attribute a continued importance to negotiation and, to the extent that this role is financially related, it is likely that clinic administrators will continue to be most financially oriented, while hospital administrators will be most

TABLE IV-31

DISTRIBUTION OF TASKS
% DELEGATING TASK TO OTHERS IN ORGANIZATION[1]

TASK	HOSPITAL ADMINISTRATORS		LONG-TERM CARE ADMINISTRATORS		CLINIC ADMINISTRATORS	
	%	RANK	%	RANK	%	RANK
Direct personnel training programs.	97.65	1	97.87	1	83.33	2.5
Coordinate maintenance and repair activities.	95.27	2	70.45	6	35.71	25
Direct and coordinate activities of nursing services.	94.67	3	95.10	2	86.67	1
Coordinate safety programs.	94.01	4	74.66	5	73.33	5
Formulate patient care policies.	92.81	5	57.24	12	66.67	6.5
Contract for purchase and delivery of supplies and services.	92.26	6	65.75	8	60.00	11
Organize health care services.	90.48	7	62.94	9	66.67	6.5
Develop personnel recruiting methods.	85.38	8	77.62	3	50.00	13
Plan and determine health care quality standards.	84.94	9	54.79	14	83.33	2.5
Coordinate personnel programs.	80.70	10	68.75	7	62.07	10
Evaluate training programs.	80.24	11	75.52	4	48.28	14
Prepare operations budget.	79.29	12	41.10	20.5	26.67	30.5

TASK	HOSPITAL ADMINISTRATORS		LONG-TERM CARE ADMINISTRATORS		CLINIC ADMINISTRATORS	
	%	RANK	%	RANK	%	RANK
Resolve employee complaints and grievances.	76.19	13	59.31	10	63.33	8.5
Investigate patient/resident complaints.	74.56	14	52.41	15	76.67	4
Conduct studies of financial performance and recommend changes.	73.37	15	31.03	28	20.00	38
Plan administrative office practices and procedures.	72.94	16	57.93	11	63.33	8.5
Negotiate reimbursement rates with third party payers.	69.64	17	45.52	17	37.93	21
Enforce administrative policies and operating procedures.	67.26	18	46.21	16	46.67	15
Plan and determine manpower requirements.	65.88	19	54.86	13	40.00	19
Solve cash flow problems.	65.27	20	39.04	24	13.33	43.5
Search the organization and its environment for more efficient operations.	61.68	21	33.10	27	41.38	17
Analyze expenditures.	61.54	22	24.66	36.5	23.33	34.5
Formulate personnel policies.	60.24	23	41.10	20.5	34.48	26.5
Formulate wage and salary pay plans.	57.06	24	34.93	25	26.67	30.5
Establish procedures for preparing and submitting reports.	55.88	25	40.56	22	36.67	23
Review and revise budget allocations.	54.17	26	27.40	33	30.00	29

TASK	HOSPITAL ADMINISTRATORS		LONG-TERM CARE ADMINISTRATORS		CLINIC ADMINISTRATORS	
	%	RANK	%	RANK	%	RANK
Interpret changes in rules and regulations (governmental policies, for example) to organizational employees.	53.80	27	23.99	38	36.67	23
Negotiate financial agreements (insurance and facilities).	53.53	28	45.21	18	16.67	41
Prepare administrative reports.	44.12	29	29.66	29	40.00	19
Interpret policies, procedures, and regulations.	37.87	30	24.66	36.5	33.33	28
Meet regulatory and accreditation requirements.	36.75	31	18.75	39	23.33	34.5
Communicate health care needs to persons external to the organization.	33.13	32	39.72	23	53.33	12
Evaluate managerial performance.	32.35	33	27.97	31	24.14	32
Allocate organizational resources to achieve organizational goals.	29.94	34	28.28	30	40.00	19
Negotiate labor union contracts.	27.56	35	26.87	34	0.00	47
Approve promotions and transfers of department heads.	24.85	36	17.24	42	17.24	40
Appoint department heads.	23.39	37	8.97	46	23.33	34.5
Keep informed of legal changes affecting the organization.	23.08	38	26.21	35	10.00	45
Approve purchases of expensive equipment.	22.94	39	33.56	26	43.33	16

TASK	HOSPITAL ADMINISTRATORS		LONG-TERM CARE ADMINISTRATORS		CLINIC ADMINISTRATORS	
	%	RANK	%	RANK	%	RANK
Represent the organization in its relationships to other health agencies.	22.35	40	18.62	40	36.67	23
Recommend to the board the rates to be charged for services.	22.16	41	15.07	44	23.33	34.5
Develop a long-range planning program for the organization.	20.12	42	27.59	32	20.00	38
Represent organization on commissions, agencies, or at hearings.	16.57	43	18.18	41	20.00	38
Write articles for professional journals of benefit to other administrators.	16.36	44	13.04	45	6.90	46
Assist medical staff with its organizational and medical-administrative problems and responsibilities.	14.88	45	43.97	19	34.48	26.5
Appoint administrative personnel.	8.19	46	14.48	43	13.79	42
Advise the board of trustees on matters requiring policy formulation.	4.76	47	8.45	47	13.33	43.5

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[1] This table shows the combined percentage of respondents who answered the questions by checking either of the two columns headed "Accomplished Indirectly" or "Performed by Others." These column headings were further explained by the statements, "This activity is a responsibility of mine, but is usually accomplished indirectly by my delegating it to others," and "This activity is not a direct responsibility of mine, but is performed by other individuals in the organization."

concerned about dealing with change and long-term care administrators may most importantly deal with staff goals and motivations in the future.

One might conclude by noting that there are substantial differences in the level of activity of the three groups of administrators in terms of those activities which they themselves perform directly. The hospital administrators appear to be broadly engaged in policy-level activities and in external representation of the organization. The clinic administrators, by contrast, are much more engaged in operational activities--especially related to financial performance. The long-term care administrators are somewhere between the other two groups, but would appear more closely related to the hospital administrators' activities than to those of the clinic administrators. While the roles were not described substantially differently, it is clear from the task activities reported in Table IV-30 that the clinic administrators do engage in substantially more "nuts and bolts" operational activities, especially related to the financial position of the clinic. Conceivably, this difference may be due to the fact that the medical staff of a clinic are in effect its stockholders and policy-makers, and are quite active in its management. In the hospital, the "stockholders" are less visible than in the clinic as may also be true in the typical long-term care facility.

Goal Attainment

Goal attainment involves the outcomes from role performance behaviors. No measures of goal attainment were developed for long-term care and clinic administrators due to the diversity of settings and the principal objective of the study to compare the role performance behaviors of these administrators with the behaviors of hospital administrators.

For hospital administrators, however, goal attainment measures were developed by asking questions about the existence of or plans for introduction of management and health care programs into the hospital organizations. Administrators were given a list of 31 management programs and asked to check one of four columns indicating long-term presence, current existence, planned introduction, or no plans regarding the program. For health care programs, ten relatively advanced health care programs (in the judgment of the research staff) were identified and respondents were asked to indicate if they presently had such a program, if they planned to add one in the next three years, or if the program was assigned to another institution/agency by the planning agency.

Table IV-32 provides data on the advanced health care programs which exist in the respondents' hospitals. Rehabilitation units, organized outpatient departments, extended care or long-term nursing units, and community health training programs are present in 40% or more of the hospitals responding to those items. Group practice clinics, surgicenters and ambulatory (inpatient) self-care units are planned additions for 40% or more of the hospitals responding to these items. Thus, of the ten advanced health care programs, all but three appear to be drawing active interest among many of the respondents. Of course, many administrators did not indicate that they were providing one or any of these services, but that is to be expected given the distribution of hospital sizes and the nature of these programs.

Table IV-33 reports the management programs which hospital administrators reported for their institutions. Most of the management programs in the upper third of the table were already in place in the hospitals. Programs in the middle third of the table were frequently reported as planned for

TABLE IV-32

HEALTH CARE PROGRAMS
HOSPITAL ADMINISTRATORS

SERVICES	PATIENT SERVICES PROVIDED BY HOSPITAL AT PRESENT		PATIENT SERVICES PLANNED FOR ADDITION WITHIN THREE YEARS		PATIENT SERVICES ASSIGNED TO OTHER HOSPITALS OR AGENCIES		PROVIDED BY HOSPITAL AT PRESENT AND ASSIGNED TO OTHER HOSPITALS OR AGENCIES		PLANNED FOR ADDITION WITHIN THREE YEARS AND ASSIGNED TO OTHER HOSPITALS OR AGENCIES		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
Rehabilitation Unit	200	51.15	75	19.18	106	27.11	5	1.28	5	1.28	391	100.00
Organized Outpatient Department	262	56.83	162	35.14	24	5.21	8	1.74	5	1.08	461	100.00
Home Care Department	102	27.57	132	35.68	123	33.24	3	0.81	10	2.70	370	100.00
Retirement Center	21	12.65	25	15.06	118	71.08	0	0.00	2	1.20	166	100.00
Ambulatory Self-Care Unit (Inpatient)	83	34.30	111	45.87	45	18.60	1	0.41	2	0.83	242	100.00
Extended Care or Long-Term Nursing Unit	184	46.35	52	13.10	146	36.78	8	2.02	7	1.76	397	100.00
Alcohol Abuse Program	154	34.76	94	21.22	182	41.08	5	1.13	8	1.81	443	100.00
Surgicenter	100	32.47	142	46.10	60	19.48	1	0.32	5	1.62	308	100.00
Community Health Training Program	153	42.74	125	34.92	74	20.67	5	1.40	1	0.28	358	100.00
Group Practice Clinic	78	29.66	123	46.77	58	22.05	1	0.38	3	1.14	263	100.00

TABLE IV-33

FORMAL MANAGEMENT PROGRAMS
HOSPITAL ADMINISTRATORS

	Have had three or more years		Added in last three years		Plan to add in next three years		Do not plan to add	
	N	%	N	%	N	%	N	%
Personnel Department............	505	69.75	86	11.88	68	9.39	65	8.98
Purchasing Department...........	591	81.18	68	9.34	35	4.81	34	4.67
Annual Personnel Budgets........	518	71.25	169	23.25	29	3.99	11	1.51
Annual Expense Budgets..........	567	77.56	149	20.38	11	1.50	4	0.55
Employee Recognition Program....	464	64.27	116	16.07	104	14.40	38	5.26
In-service Education Program....	565	76.98	154	20.98	14	1.91	1	0.14
Policy and Procedure Manual.....	586	79.84	129	17.57	18	2.45	1	0.14
Cash Flow Budget................	369	51.25	211	29.31	107	14.86	33	4.58
Community Relations Program.....	281	39.69	211	29.80	156	22.03	60	8.47
Trustee Education Program.......	173	24.71	230	32.86	198	28.29	99	14.14
Labor Relations Specialist......	130	18.68	149	21.41	98	14.08	319	45.83
Program Budgeting...............	272	39.08	178	25.57	143	20.55	103	14.80
Cost/Benefit Analyses...........	208	30.06	177	25.58	202	29.19	105	15.17
Employee Health Service.........	420	59.07	121	17.02	86	12.10	84	11.81
Service Area Market Studies.....	124	18.13	170	24.85	140	20.47	250	36.55
Long-Range Planning (programs)..	295	41.26	258	36.08	137	19.16	25	3.50
Long-Range Planning (facilities)	297	41.83	239	33.66	121	17.04	53	7.46
Capital Expansion Program.......	289	40.93	195	27.62	135	19.12	87	12.32
Job Evaluation Program..........	398	55.28	200	27.78	92	12.78	30	4.17
Management by Objectives Program	126	18.03	169	24.18	188	26.90	216	30.90
Reorganization Studies..........	135	19.54	196	28.36	186	26.92	174	25.18
Systems Engineering Program.....	104	14.99	133	19.16	200	28.82	257	37.03
Cost Containment Programs.......	211	29.55	308	43.14	147	20.59	48	6.72
Management Appraisal Program....	175	25.33	172	24.89	235	34.01	109	15.77
Shared Service Programs.........	297	41.89	218	30.75	114	16.08	80	11.28
Outside Service Contracts.......	400	56.50	168	23.73	27	3.81	113	15.96
Prof. Standards Review Program..	102	14.17	367	50.97	217	30.14	34	4.72
Management Information Systems..	168	24.35	194	28.12	162	23.48	166	24.06
Computerized Manpower Planning..	43	6.28	71	10.36	173	25.26	398	58.10
Health Maintenance Organization.	13	1.89	26	3.78	76	11.06	572	83.26
Problem Oriented Medical Records	67	9.68	159	22.98	262	37.86	204	29.48

short-term introduction if they were not already present, with the exception of a labor relations specialist and service area market studies. Perhaps the impact of recent labor law changes has not yet touched hospitals. Market studies also are unlikely to be conducted by all hospitals at any point, let alone in the next three years. The programs grouped in the bottom third of Table IV-33 are on the whole not present at this time in hospitals although many are candidates for introduction. Notable among those management programs reported as not being planned for addition are health maintenance organizations and management by objectives programs.

SUMMARY: INSTITUTIONAL DIFFERENCES

Defining the managerial role and developing a task description of the chief executive's activities in health delivery organizations is by no means a simple task. On the whole, however, in broadly defined terms executive roles are similar across these organizations. It also appears that the clinics are distinctive in the heavy emphasis their executives place on direct financial analysis activities. The congruence in rankings between the time consumed and the importance of the various managerial roles and the increasing outside role of the hospital administrator of the future are both significant. The present importance and the anticipated importance of the Disturbance Handler role in both the long-term care facility and in clinics is of interest, but of a somewhat unclear implication. The same is true regarding the increased importance of the Negotiator role in the future for clinic administrators.

There are further implications for defining the jobs of executives in these three institutional settings. The hospital administrator clearly is a policy-developer and policy-implementer. The clinic administrator is substantially more of a financial operations officer. The long-term care administrator plays a mixed role which in turn may be more difficult. We may perhaps infer from these different roles and the anticipated future roles that becoming a hospital chief executive officer will be substantially more difficult than becoming a clinic administrator. We might also anticipate that clinic administrators will in the future be generally younger than hospital administrators, although at the present time, there is no significant difference in the ages of administrators from the three groups of institutions.

Profiling the health organization chief executive officer has been the purpose of this section. This profile has been based on a national questionnaire sample of hospital, long-term care facility, and clinic administrators. Surprising similarity between broadly defined roles exists across institutional settings, while a more specific activity focus has found hospital administrators to be more policy-oriented and clinic administrators to be more fiscally-oriented. Long-term care facility administrators appear to combine both types of tasks.

III. DIFFERENCES WITHIN INSTITUTIONAL TYPES

This section reviews data on differences: a) between hospital respondents based on institutional size, administrator education, and administrator perceptions of role change for dependent variables related to role senders' influence, role perceptions, and managerial role descriptions and activities; and b) between long-term care respondents based on institutional size, administrator education, and administrator perceptions of role change for dependent variables related to role sender's influence, role perceptions, and managerial role descriptions.

The analyses and tables are based upon a one-way analysis of variance using size, education, and role change perception as the independent or classification variable. The goal of this section is to identify dependent variables which are influenced by these independent variables.

HOSPITAL ADMINISTRATORS

Differences by Bed Size

Tables IV-34 through IV-37 identify variables for which there are significant differences in hospital administrator's responses based on the bed size of the hospital. Table IV-34 indicates that there were overall significant differences in the analysis of variance for three dependent variables but that there were significant differences between two group means for five additional variables. Administrators of small hospitals reported department heads and state hospital associations had more influence over their patient care program development than did administrators of medium or large size hospitals. Some administrators of medium size hospitals expected more future influence from Blue Cross than did the other two groups, although still not many reported this expectation. Administrators of larger hospitals reported more influence from state/local government, community interest groups, present and future, planning agencies and competing hospitals.

Table IV-35 reports data for differences in role perceptions or goal importance. In all three cases administrators of larger hospitals assigned a higher mean value to these goals than did administrators of the other two groups. For the 11 other goals/role perceptions, there were no differences between the groups.

TABLE IV-34

HOSPITAL ADMINISTRATORS
SIGNIFICANT DIFFERENCES IN ROLE SENDERS' INFLUENCE

BED SIZE CLASSIFICATION VARIABLE

	bed/sizes:	50-99	100-299	300+
Dependent Variables	Overall Difference	Mean	Mean	Mean
Department Heads		3.342*	3.207*	3.247
State Hospital Association	##	2.113++	2.007**	1.792**++
Blue Cross/Blue Shield-future		.0583*	.1059*	.0886
State/Local Government		2.444	2.410*	2.625*
Community Interest Groups		2.090*	2.178	2.261*
Community Interest Groups-future		.1208*	.1464	.2089*
Health Planning Agencies	#	2.128*+	2.325*	2.373+
Competing Hospitals	##	1.924**++	2.193**	2.329++

#, +, * .05 level of significance

##, ++, ** .01 level of significance

Matched symbols indicate t-test differences between means.

The overall difference column refers to the significance of the F-ratio from a one-way analysis of variance.

Present responses were scaled: Major = 4; Some = 3; Little = 2; None = 1.

Future responses were scaled: More future influence = 1; no change in influence = 0.

TABLE IV-35

HOSPITAL ADMINISTRATORS
SIGNIFICANT DIFFERENCES IN ROLE PERCEPTIONS

BED SIZE CLASSIFICATION VARIABLE

	bed sizes:	50-99	100-299	300+
Dependent Variables	Overall Difference	Mean	Mean	Mean
Teaching	##	52.52**++	59.14**##	67.73++##
Research	##	19.81**	22.51++	35.65**++
Planned Improvement of Administrative Services		70.34	68.96*	73.97*

#, +, * .05 level of significance

##, ++, ** .01 level of significance

Matched symbols indicate t-test differences between means.

The overall difference column refers to the significance of the F-ratio from a one-way analysis of variance.

Responses were scaled: 100 = Very Important; 50 = Moderately Important; 0 = Not Important; intermediate scale points were also available for responses although not labeled.

Table IV-36 summarizes the data for differences in managerial activities' ratings for time consumed, importance, and anticipated importance of the activities, as well as for three combined variables for each period referred to as policy, internal management, and outside activities and defined in the notes to the table. Administrators of small hospitals attribute a higher rating to the time consumed, importance and anticipated importance of financial management and personnel management and to the time consumed of coordinating department operations. Administrators of larger hospitals scored planning-facility and program, health industry activities, and government related activities higher in time consumed than the other two groups; program review and evaluation and planning-facility and program higher in importance; and planning-facility and program and public and community activities higher in anticipated importance. For the combined variables, administrators of larger hospitals scored policy higher in time consumed, importance and anticipated importance while administrators of small hospitals considered internal management more important in each category. In addition, outside activities were more time consuming for administrators of large hospitals.

Table IV-37 reports differences in managerial role descriptions. The Resource Allocator role shows two overall differences and a pair-wise difference for time consumed. Leader and Liaison roles differ by groups for importance and anticipated importance while Monitor and Disturbance Handler roles differ for time consumed. The combined variables for Interpersonal Roles differ for the three questions between pairs while the Decision-making roles differ in time consumed and anticipated importance.

Differences by Education

Tables IV-38 and IV-39 identify variables for which there are significant differences in hospital administrator's responses based on the education of the administrator. In Table IV-38, the only role perception for which there is a difference is for planning for expansion of facilities (for which MHA graduates

TABLE IV-36

HOSPITAL ADMINISTRATORS
SIGNIFICANT DIFFERENCES IN MANAGERIAL ACTIVITIES

BED SIZE CLASSIFICATION VARIABLE

	bed sizes:	50-99	100-299	300+
Dependent Variable	Overall Difference	Mean	Mean	Mean
Financial Management-time consumed	##	3.800**++	3.469++	3.242**
Personnel Management-time consumed	##	3.274**++	2.855++	2.839**
Coordinating Department Operations-time consumed	##	3.809**+	3.474+	3.210**
Planning-Facility and Program-time consumed	##	3.086**++	3.445**	3.581++
Health Industry Activities-time consumed		2.341*	2.573	2.726*
Government Related Activities-time consumed		2.628*	2.920*	2.951
Financial Management-importance	##	3.923#**	3.651+#	3.350**+
Personnel Management-importance	##	3.176**+	2.944+	2.750**
Program Review & Evaluation-importance		2.886*+	3.164*	3.177+
Planning-Facility and Program-importance		3.202*	3.425	3.557*
Financial Management-anticipated importance	##	3.809**+	3.495+	3.220**
Personnel Management-anticipated importance	##	3.068**+	2.785+	2.542**
Planning-Facility and Program-anticipated importance		3.012*	3.183	3.417*
Public and Community Activities-anticipated importance		2.814*	3.028	3.153*
Policy-time consumed	##	9.644*++	10.210*	10.419++
Internal Management-time consumed	##	10.872**++	9.821++	9.290**
Outside Activities-time consumed	##	9.407*++	10.088*	10.443++
Policy-importance	#	10.218**	10.564	10.918**
Internal Management-importance	##	10.393#**	9.891++#	9.220++**
Policy-anticipated importance	#	9.619**	9.891	10.397**
Internal Management-anticipated importance	##	9.833++##	9.110##*	8.466++*

#, +, *   .05 level of significance

##, ++, ** .01 level of significance

Matched symbols indicate t-test differences between means.

The overall difference column refers to the significance of the F-ratio from a one-way analysis of variance.

Responses were scaled: 1 = Least (time consumed, importance, anticipated importance); 2 = Below Average (time consumed, importance, anticipated importance); 3 = Average (time consumed, importance, anticipated importance); 4 = Above Average (time consumed, importance, anticipated importance); and 5 = Most (time consumed, importance anticipated importance).

Policy, Internal Management, and Outside Activities variables are sums of basic variables:
Policy = Determination of Goals and Objectives + Program Review and Evaluation + Planning-Facility and Program. Range: 3 to 13.
Internal Management = Financial Management + Personnel Management + Coordinating Department Operations. Range: 3 to 13.
Outside Activities = Public and Community Activities + Health Industry Activities + Government Related Activities + Educational Development. Range: 8 to 16

TABLE IV-37

HOSPITAL ADMINISTRATORS
SIGNIFICANT DIFFERENCES IN MANAGERIAL ROLE DESCRIPTIONS

BED SIZE CLASSIFICATION VARIABLE

	bed sizes:	50-99	100-299	300+
Dependent Variables	Overall Difference	Mean	Mean	Mean
The Monitor Role-time consumed		3.290*	3.580*	3.442
The Disturbance Handler Role-time consumed	##	2.881++	2.692*	2.341++*
The Resource Allocator Role--time consumed		3.159*	3.416*	3.370
The Leader Role-importance		4.127*	3.823*	3.935
The Liaison Role-importance	#	3.043**	3.052++	3.553++**
The Resource Allocator Role-Importance	#	3.029*	3.369*	3.326
The Leader Role-Anticipated Importance	#	3.833**	3.429**	3.667
The Liaison Role-Anticipated Importance		3.469	3.357*	3.761*
The Resource Allocator Role-Anticipated Importance	#	2.892**	3.345**	3.190
Interpersonal Roles-Time Consumed		8.657	8.500*	9.089*
Decision Making Roles-time consumed		12.87*	12.66	12.07*
Interpersonal Roles-importance		8.791	8.709*	9.283*
Interpersonal Roles-anticipated importance		9.048	8.606*	9.273*
Decision Making Roles-anticipated importance		12.27*	12.98*	12.56

#, +, * .05 level of significance

##, ++, ** .01 level of significance

Matched symbols indicate t-test differences between means.

The overall difference column refers to the significance of the F-ratio from a one-way analysis of variance.

Responses were scaled: 1 = Least (Time Consumed, Importance, Anticipated Importance); 2 = Below Average (Time Consumed, Importance, Anticipated Importance); 3 = Average (Time Consumed, Importance, Anticipated Importance); 4 = Above Average (Time Consumed, Importance, Anticipated Importance); and 5 = Most (Time Consumed, Importance, Anticipated Importance).

Interpersonal, Informational and Decision Making variables are sums of basic variables:
Interpersonal = The Figurehead role + The Leader role + The Liaison role. Range: 5 to 13.
Informational = The Monitor role + The Disseminator role + The Spokesman role. Range: 5 to 13.
Decision-Making = The Entrepreneur role + The Disturbance-Handler role + The Resource Allocator role + The Negotiator role. Range: 8 to 16.

TABLE IV-38

HOSPITAL ADMINISTRATORS
SIGNIFICANT DIFFERENCES IN ROLE PERCEPTIONS AND ROLE SENDER'S INFLUENCE

DEGREE-MAJOR CLASSIFICATION VARIABLE

DEGREE-MAJOR:		NONE	BA-MA	OTHER ADVANCED	MBA	MHA	BBA
DEPENDENT VARIABLES	OVERALL DIFFERENCE	MEAN	MEAN	MEAN	MEAN	MEAN	MEAN
Planning for Expansion of Facilities	#	60.840	60.790	58.490	60.500	69.850	61.620
Department Heads	#	3.408	3.283	3.278	3.094	3.206	3.416
Patients	##	2.831	2.804	2.838	2.600	2.504	2.657
State Hospital Association	##	2.296	2.143	1.722	1.900	1.874	2.196
J.C.A.H.	#	2.561	2.543	2.865	2.533	2.359	2.667
J.C.A.H.--Future	##	0.095	0.060	0.189	0.000	0.098	0.181
A.H.A.	##	2.029	2.029	1.892	2.103	1.774	2.100
Blue Cross/Blue Shield	##	2.386	2.231	2.000	2.000	2.009	2.310
Federal Government	##	2.917	2.788	2.892	2.433	2.516	2.725
State/Local Government	##	2.515	2.548	3.243	2.433	2.331	2.524

# .05 level of significance

## .01 level of significance

The overall difference column refers to the significance of the F-ratio from a one-way analysis of variance.

Variables are scaled as on Tables IV-34 and IV-35.

scored highest). Only one difference appears for the increased future influence of role senders--for the Joint Commission on Accreditation of Hospitals. There are eight differences for the present influence of the 14 role senders identified, but no clear pattern of one educational group attributing more overall influence to role senders emerges. What is interesting is that perceptions of the influence of role senders such as the board, medical staff, administrative staff, community interest groups, health planning agencies, and competing hospitals do not differ by educational background of administrator. The board, medical staff, and administrative staff are rated uniformly high in influence while community interest groups, health planning agencies, and competing hospitals are rated uniformly low.

Table IV-39 shows differences in managerial activities and roles by education. Many differences in activities appear but only three managerial roles showed a difference. Differences in activities related to financial management and personnel management occur for the time consumed, importance, and anticipated importance questions. The time consumed by planning-facility and program and the anticipated importance of coordinating department operations, program review and evaluation, and educational development also show differences by educational category. For the combined variables policy differs for all three questions while internal management differs for the importance and anticipated importance questions.

Differences by Perceptions of Role Change

Table IV-40 provides data on differences in the variables based on the hospital administrators' responses to the question, "Do you believe your role(s) [functions] will change in the future?" Goals related to shared services and cost containment were scored higher by those who expect their role to change and more future influence was attributed to their boards and to the federal government by these respondents.

TABLE IV-39

HOSPITAL ADMINISTRATORS
SIGNIFICANT DIFFERENCES IN MANAGERIAL ACTIVITIES AND MANAGERIAL ROLE DESCRIPTIONS

DEGREE-MAJOR CLASSIFICATION VARIABLE

Degree-Major:		NONE	BA MA	OTHER ADVANCED	MBA	MHA	BBA
Dependent Variables	Overall Difference	Mean	Mean	Mean	Mean	Mean	Mean
Financial Management-Time Consumed	#	3.821	3.698	2.947	3.875	3.515	3.591
Personnel Management-Time Consumed	#	3.500	2.930	3.050	2.500	2.915	3.256
Planning-Facility and Program-Time Consumed	#	2.821	3.310	3.200	3.250	3.547	3.095
Financial Management-Importance	#	4.037	3.628	3.263	4.000	3.672	3.707
Personnel Management-Importance	##	3.385	2.814	2.895	2.875	2.913	3.317
Financial Management-Anticipated Importance	#	3.680	3.439	2.944	4.000	3.606	3.595
Personnel Management-Anticipated Importance	#	3.125	2.698	2.684	2.625	2.718	3.146
Coordinating Department Operations-Anticipated Importance	#	2.792	2.775	3.105	3.250	2.645	3.186
Program Review and Evaluation-Anticipated Importance	#	2.957	3.000	3.529	3.000	3.033	2.725
Educational Development-Anticipated Importance	##	1.875	1.756	2.632	1.875	1.876	2.238
Policy-Time Consumed	##	9.040	9.829	10.000	10.125	10.365	9.439
Policy-Importance	#	10.000	10.683	10.444	10.625	10.718	9.711
Internal Management-Importance	#	10.462	9.610	9.722	10.250	9.727	10.615
Policy-Anticipated Importance	##	9.174	10.000	10.235	10.500	10.059	9.000
Internal Management-Anticipated Importance	#	9.591	8.949	8.833	9.875	8.983	10.000
The Disturbance Handler Role-Time Consumed	##	2.760	2.854	2.900	2.800	2.441	3.129
The Liaison Role-Importance	##	2.880	3.282	2.273	2.444	3.308	3.032
The Liaison Role-Anticipated Importance	##	3.080	3.649	2.545	3.889	3.583	3.226

# .05 level of significance

## .01 level of significance

The overall difference column refers to the significance of the F-Ratio from a one-way analysis of variance.

Variables are scaled and derived as on Tables IV-36 and IV-37.

TABLE IV-40

HOSPITAL ADMINISTRATORS
SIGNIFICANT DIFFERENCES IN ROLE PERCEPTIONS, ROLE SENDERS' INFLUENCE, MANAGERIAL ACTIVITIES, MANAGERIAL ROLE DESCRIPTIONS
ROLE CHANGE CLASSIFICATION VARIABLE

Variable	Overall Difference	Yes Mean	No Mean
Cost Containment	#	85.870	83.400
Shared Services With Other Hospitals	##	57.150	49.660
Board - future	#	.271	.193
Federal Government - future	#	.327	.243
Financial Management - time consumed	#	3.481	3.738
Health Industry Activities - time consumed	#	2.635	2.318
Government Related Activities-anticipated importance	##	3.799	3.383
Internal Management - time consumed	#	9.930	10.544
Outside Activities - anticipated importance	##	11.370	10.560
The Leader Role - importance	##	3.827	4.171
The Spokesman Role - importance	##	2.783	2.456
The Leader Role - anticipated importance	##	3.447	3.904
The Spokesman Role - anticipated importance	#	3.007	2.750
Interpersonal Roles - time consumed	#	8.520	9.000

# .05 level of significance

## .01 level of significance

The overall difference column refers to the significance of the F-ratio from a one-way analysis of variance.

Variables are scaled and derived as on Tables IV-34, IV-35, IV-36, and IV-37.

Those who expected their role to change currently spent less time on financial management and more time on health industry activities and anticipated that government related activities would have more future importance. They spent less time on internal management and believed that in the future they would spend more time on outside activities. In terms of their managerial roles those who believed their role would change, currently and in the future attributed more importance to the spokesman role and less importance to the leader role than those who did not think their role would change. In summary, it appears that the respondents from hospitals who expected their role to change, see it moving toward a role of representative and information provider for their institution to other health care providers and to governmental agencies.

LONG TERM CARE ADMINISTRATORS

Differences by Bed Size

Table IV-41 identifies role perception, role senders' influence and managerial role description differences by bed size categories for long term care administrators. Administrators of small facilities value shared services more highly as might be expected. No differences in the present influence of role senders exists by bed size groups, but five differences exist in expectations of future influence. Administrators of larger facilities anticipate more influence from their boards, patients, professional associations, community interest groups, and health planning agencies. Role differences appear for the leader, liaison, and monitor roles in terms of time consumed, for the importance of the leader and disturbance handler roles and for the anticipated importance of the disturbance handler, figurehead, and spokesman roles. For the combined variables, differences by bed size appear for the interpersonal and informational roles' importance and anticipated importance.

TABLE IV-41

LONG TERM CARE ADMINISTRATORS
SIGNIFICANT DIFFERENCES IN ROLE PERCEPTIONS, ROLE SENDER'S INFLUENCE, AND MANAGERIAL ROLE DESCRIPTIONS
BED SIZE CLASSIFICATION VARIABLE

Variable	Overall Difference	Bed Size: 50-99 Mean	Bed Size: 100-299 Mean	Bed Size: 300+ Mean
Shared Services with Other Health Care Providers		54.690*	39.790*	44.580
Board - future	##	.059**	.165++	.500**++
Patients - future		.118*	.175+	.417*+
Professional Association - future	#	.059+	.052*	.250*+
Community Interest Groups - future		.059*	.144	.333*
Health Planning Agencies - future	#	.029**	.237**	.250
The Leader Role - time consumed	#	4.600**	4.045**	4.000
The Liaison Role - time consumed		2.759	2.709*	3.400*
The Monitor Role - time consumed		3.355	3.273*	3.900*
The Leader Role - importance	#	4.704*	4.212*	4.091
The Disturbance Handler Role - importance	#	2.714*	3.123*	2.667
The Figurehead Role - anticipated importance	#	2.478*+	1.877+	1.500*
The Spokesman Role - anticipated importance		2.500*	2.600+	3.300*+
The Disturbance Handler Role-anticipated importance	#	2.818	2.950*	2.111*
Interpersonal Roles - importance	#	9.923*++	8.852++	8.556*
Informational Roles - importance		7.750*	8.395	9.111*
Interpersonal Roles - anticipated importance		9.571*	8.671*	8.600
Informational Roles - anticipated importance		8.000*	8.410	9.300*

#, +, * .05 level of significance

##, ++, ** .01 level of significance

Matched symbols indicate t-test differences between means.

The overall difference column refers to the significance of the F-ratio from a one-way analysis of variance.

Variables are scaled and derived as on Tables IV-34, IV-35, and IV-37.

Differences by Education

Table IV-42 summarizes differences for dependent variables by the education of the long term care administrators. Teaching, research, and shared services are identified as more highly valued goals by administrators with no degree than by either of the other categories. Those respondents with no degree attributed more influence to the medical staff while those with non-health, non-business degrees attributed least influence to their administrative staffs. In terms of expected future influence, those with no degrees anticipated the most increased influence for their administrative staffs and for competing organizations. For managerial roles, only the monitor and disseminator roles showed differences by education for time consumed and only the monitor role for importance. No differences appeared for the anticipated importance of the roles.

Differences by Perception of Role Change

Table IV-43 shows the significant differences by the respondent's perception of whether his/her role will change. Very few differences are significant. Those who do not expect their role to change attribute more present influence to the medical staff and to Blue Cross/Blue Shield and less of an increase in influence to the federal government. They also believe the anticipated importance of the leader role is greater. The leader role involves interpersonal relationships with, and motivation of, subordinates. It appears that those who do not expect their role to change anticipate a continued high importance to a personalistic leadership/management style.

TABLE IV-42

LONG TERM CARE ADMINISTRATORS
SIGNIFICANT DIFFERENCES IN ROLE PERCEPTIONS, ROLE SENDERS' INFLUENCE, MANAGERIAL ROLE DESCRIPTIONS DEGREE - MAJOR CLASSIFICATION VARIABLES

Variable	Overall Difference	Degree-Major		
		None Mean	BA-MA Mean	MHA, BBA, MBA Mean
Teaching	#	71.020**	57.330**	63.570
Research	##	46.160**+	27.540**	32.330+
Shared Services with Other Health Care Providers	#	53.220*+	41.480+	37.170*
Medical Staff	##	3.532**+	3.217+	3.000**
Administrative Staff	#	3.816	3.625*	3.897*
Administrative Staff - future		.173*	.082	.032*
Competing Organizations - future		.096*	.000*	.032
Monitor Role - time consumed	#	3.617*+	3.163*	3.172+
Disseminator Role - time consumed		2.543*	2.600	3.000*
Monitor Role - importance	#	3.619**+	3.195**	3.222+

#, +, * .05 level of significance

##, ++, ** .01 level of significance

Matched symbols indicate t-test differences between means.

The overall difference column refers to the significance of the F-ratio from a one-way analysis of variance.

Variables are scaled and derived as on Tables IV-34, IV-35, and IV-37.

TABLE IV-43

LONG TERM CARE ADMINISTRATORS
SIGNIFICANT DIFFERENCES IN ROLE SENDERS' INFLUENCE,
MANAGERIAL ROLE DESCRIPTIONS
ROLE CHANGE CLASSIFICATION VARIABLE

Variable	Overall Difference	Yes Mean	No Mean
Medical Staff	#	3.123	3.443
Blue Cross/Blue Shield	#	1.754	2.113
Federal Government - future	#	.412	.235
The Leader Role - anticipated importance	#	3.625	4.017

# .05 level of significance

The overall difference column refers to the significance of the F-ratio from a one-way analysis of variance.

Variables are scaled as on Tables IV-34 and IV-37.

SUMMARY: DIFFERENCES BETWEEN INSTITUTIONAL TYPES

This section has examined differences between hospital respondents in terms of size of facility, education, and role change perceptions as well as differences between groups of long-term care administrators in terms of the same variables. As would be expected, there were differences in responses in terms of size, education, and perception of future change.

Administrators of smaller hospitals spent more time on internal operations such as finance and personnel than did those in the larger hospitals. The chief executive officers in larger hospitals devoted their time more to external activities such as community and governmental relations. More attention was given to policy activities in larger hospitals, while more attention was given to internal management in smaller hospitals.

In terms of education, it was noted that MHA graduates scored highest on the goal, planning for expansion of facilities. This is no doubt due to the fact that these graduates tend to be found in hospitals which are located in communities which are expanding and in facilities where education and research are emphasized. There appeared to be few differences in perceptions about the degree of future influence of various role senders based upon administrators' backgrounds.

Those who expected their roles to change in the future expected more influence from their boards of trustees and the federal government. Also, these respondents spent less time on financial management and more time on health industry activities. They believed they would spend even more time on external functions in the future. It was pointed out that those who see their role changing in the future believed they would represent the hospital more to external forces in the future.

Long-term care administrators differed by bed size category in their expectations of future influence for boards of trustees, patients, professional associations, community interest groups, and health planning agencies. The future was expected to give more attention to the importance of the Disturbance-Handler, Figurehead, and Spokesman roles. Educational differences also were noted for some variables. Those with no degrees anticipated more future influence from their administrative staffs and competing organizations.

ROLE DELINEATION: SUMMARY COMMENTS

The roles, activities, and tasks data for hospital administrators were reviewed in Chapter 2, while the data from long-term care and clinic administrators were reviewed in the second section of this chapter. Comparisons of the three groups of administrators were made in Tables IV-25, IV-26, and IV-27 for the managerial roles data, and Tables IV-30 and IV-31 for the tasks data.

A key remaining question is how the activities, roles, and tasks relate to each other. While it would have been useful to ask all respondents to answer all three sets of questions, the length of such a questionnaire surely would have prevented any reasonable response rate. Thus, data from the same respondents for all questions are not available. Yet, it is possible to cross-classify most of the roles, activities, and tasks with each other on a heuristic basis with a fair degree of confidence. The managerial role definitions are reproduced as Table IV-44; the managerial activity definitions are reproduced as Table IV-45. Table IV-46 presents a combined picture of the roles, activities, and tasks.

Clearly, the correspondence of roles, activities, and tasks is not perfect

TABLE IV-44

MANAGERIAL ROLE DESCRIPTIONS
(Based on Mintzberg, 1973)

Interpersonal Roles

The Figurehead Role: The chief executive is a symbol required by the status of his office to carry out a variety of social, legal, and ceremonial duties in which he represents the organization.

The Leader Role: The chief executive has interpersonal relationships with his subordinates; as he hires, trains, and motivates them, he must essentially bring their needs in accord with those of the organization.

The Liaison Role: The chief executive has interpersonal relationships with people outside of his, own organization and spends a considerable amount of time developing a network of high-status contacts in which information and favors are traded for mutual benefit and through which the chief executive exerts community leadership.

Informational Roles

The Monitor Role: The chief executive continually seeks and receives information about his organization in order to understand changing situations and his organization's environment.

The Disseminator Role: The chief executive shares some of the environmental information with his subordinates.

The Spokesman Role: The chief executive informs outsiders about the progress, problems, and activities of his organization.

Decisional Roles

The Entrepreneur Role: The chief executive takes the responsibility for bringing about changes in his organization, looking for problems and opportunities, and then initiating projects to deal with them.

The Disturbance Handler Role: The chief executive takes charge when his organization faces a major disturbance or crisis and deals with the resulting problems.

The Resource Allocator Role: The chief executive decides who will get what in his organization; he establishes priorities, designs his organization, and authorizes all important decisions.

The Negotiator Role: The chief executive takes charge whenever his organization must enter into crucial negotiations with other parties; his presence is required because he has the information and the authority to make the decisions that difficult negotiations require.

TABLE IV-45

MANAGERIAL ACTIVITIES

Determination of Goals and Objectives: This consists primarily of activities dealing with policy-making committees and boards, where the subject matter concerns overall hospital policy.

Financial Management: This classification relates to the internal financial affairs of the hospital. It includes budgeting, both development and review.

Personnel Management: This category relates to the selection, evaluation, and motivation of employees. It includes wage and salary administration/determination.

Coordinating Department Operations: This category includes activities dealing with the internal functioning of any hospital department. Routine meetings with department heads would be one example, unless the subject matter clearly belonged in a different classification.

Program Review and Evaluation: This relates to the general functioning of the clinical services. It is concerned primarily with the evaluation and review of various projects and programs.

Planning-Facility and Program: This classification refers primarily to the activities involved in remodeling projects, space problems, and new facility construction as well as new services and programs. It does not include financing, personnel, etc.

Public and Community Activities: This classification concerns activities related to the development and maintenance of interaction with other health service-providing institutions/agencies, including shared service arrangements with other providers, coordination, etc.

Health Industry Activities: This classification refers to activities that are external to the hospital. It includes participation in hospital associations, professional societies, etc.

Government Related Activities: This activity is concerned with the legal problems of the hospital plus the activities in dealing with local, state, or federal agencies.

Educational Development: This category includes all teaching and lecturing responsibilities, plus personal continuing education.

and some combinations may even seem arbitrary--e.g., Coordinating Department Operations and the Disturbance-Handler role. Yet, other groups fit quite obviously--the Entrepreneur role of change-initiator directly relates to Determination of Goals and Objectives and Planning-Facility and Program. Matching the individual tasks to the roles and activities is somewhat more difficult and more open to debate. The Monitor role is matched with the Program Review and Evaluation activity, but the first two tasks under this group could just as easily be matched with Financial Management activities and the Resource Allocator role. They appear here because they represent information seeking tasks--related to monitoring the organization. Groupings of this sort are, of course, always subject to debate.

Drawing on the combinations of tasks, roles, and activities of Table IV-46, a number of points are worth noting. Some role-activity combinations were not well represented in the list of tasks. Others may have been over-represented. Furthermore, even for the groups for which there is a high congruence from all three sets of data--notably for the Leader role and Personnel Management and Educational Development activities, there are sharp contrasts in the tasks directly performed by the chief executive versus those delegated. The first four tasks under the Leader role are among those performed by 67% or more of the hospital chief executives, while the last four are among those performed directly by 20% or fewer of the hospital chief executives. A similar split between regularly performed and frequently delegated tasks exists for the Entrepreneur and Monitor roles, and the associated tasks.

These points suggest the complexity of the data. Again, looking at the

TABLE IV-46

MANAGERIAL ROLES, ACTIVITIES, AND TASKS

Role: The Entrepreneur.

Activity: Determination of Goals and Objectives.
Planning Facilities and Program.

Tasks: Advise the Board of Trustees on matters requiring policy formulation.

Develop a long-range planning program for the organization.

Search the organization and its environment for more efficient operations.

Plan and determine manpower requirements.

Plan and determine health care quality standards.

Formulate health care policies.

Role: The Leader.

Activity: Personnel Management.
Educational Development.

Tasks: Appoint administrative personnel.

Appoint department heads.

Approve promotions and transfers of department heads.

Evaluate managerial performance.

Formulate wage and salary pay plans.

Formulate personnel policies.

Evaluate training programs.

Coordinate personnel programs.

Develop personnel recruiting methods.

Direct personnel training programs.

Role: The Monitor.

Activity: Program Review and Evaluation.

Tasks: Keep informed of legal changes affecting the organization.

Meet regulatory and accreditation requirements.

Analyze expenditures.

Conduct studies of financial performance and recommend changes.

Role: The Resource Allocator.

Activity: Financial Management.

Tasks: Approve purchases of expensive equipment.

Recommend to the Board the rates to be charged for services.

Allocate organizational resources to achieve organizational goals.

Review and revise budget allocations.

Prepare operations budget.

Role: The Liaison.

Activity: Public and Community Activities.

Tasks: Assist medical staff with its organizational and medical-administrative problems and responsibilities.

Represent organization on commissions, agencies, or at hearings.

Represent the organization in its relationships to other health agencies.

Role: The Negotiator.

Activity: Government-Related Activities.

Tasks: Negotiate financial agreements (insurance and facilities).

Negotiate reimbursement rates with third party payers.

Negotiate labor union contracts.

Contract for purchase and delivery of supplies and services.

Role: The Spokesman.

Activity: Health Industry Activities.

Tasks: Communicate health care needs to persons external to the organization.

Write articles for professional journals of benefit to other administrators.

Role: The Disturbance-Handler.

Activity: Coordinating Department Operations.

Tasks: Establish procedures for preparing and submitting reports.

Solve cash flow problems.

Enforce administrative policies and operating procedures.

Plan administrative office practices and procedures.

Investigate patient/resident complaints.

Resolve employee complaints and grievances.

Organize health care services.

Coordinate safety programs.

Coordinate maintenance and repair activities.

Direct and coordinate activities of nursing services.

Role: The Disseminator.

Activity: No activity was included.

Tasks: Interpret policies, procedures, and regulations.

Prepare administrative reports.

Interpret changes in rules and regulations (governmental policies, for example) to organizational employees.

Role: The Figurehead.

Activity: No activity was included.

Tasks: No tasks were included.

Leader role, hospital chief executive officers' perception of personnel management is not a technical skill orientation, but rather a concern over managing senior staff members. Their concern with financial affairs is as a broad overseer, rather than as the bookkeeper's supervisor.

The educational implications are quite different, depending upon how one interprets Table IV-46. The more appropriate interpretation utilizes the first few tasks under each role as a further specification of the role, since it is these first few tasks which are among those most frequently directly performed by the hospital chief executives. As one reads down the task lists, the tasks are less frequently performed by the hospital chief executives and more frequently delegated and thus are not as critical an element of the role.

Again, caution in these interpretations is needed, since three different groups responded separately to the roles, activities, and tasks questions. Yet, there does appear to be a fair degree of consistency in the integration of the three sets of data provided in Table IV-46. A useful strategy for future research would be to ask chief executives to develop task statement examples, based on the definitions of the roles and activities provided. Such a procedure would clarify the data developed in the questionnaire responses and expand the understanding of the chief executive officers' role. Further refinement of the job element components of health services administration positions at various levels is essential to development of appropriate pre-career and continuing education programs. Understanding what executives really do is a first step before educators may adequately prepare them to do it. Table IV-46, and the other role delineation data discussed in this report, are a first attempt at such an understanding.

CHAPTER V

CHANGING ISSUES IN HOSPITAL ADMINISTRATION

The growing importance of the administrator's role in the hospital is a function of several factors including increased specialization and organizational differentiation, changing technology, and increasing expectations of consumers, which require increased coordination and organizational adjustment to change. In light of these changing responsibilities, it is important that the future role of the administrator be investigated in terms of the nature of present and expected changes, causes for changes and implications for present and future administrators.

The overall research project was a study of the role of the health care administrator at the present time and of the anticipated changes which will occur in the health care administration role in the next 10 to 15 years. This section of the project was conducted in four phases.

One phase involved an extensive series of interviews with leading hospital administrative personnel. The second phase of this chapter involved interviews with what we have termed "role senders;" that is, individuals external to the hospital who are influencing what happens within the hospital setting itself. Such individuals include officials from Blue Cross--type organizations, state planning agencies, local planning agencies, Professional Standards Review Organizations (PSRO's), and Health Maintenance Organizations (HMO's).

A third phase consisted of interviews with representatives of educational institutions and professional associations. The final phase was the development of a Delphi instrument summarizing statements gathered from the non-directive interviews. The Delphi was completed by those who had been interviewed in the earlier phases.

The results of these four phases of data collection are reported in the following sections of this chapter.

1. The hospital administrative personnel interviews.
2. Interviews with professionals associated with hospital administrators externally.
3. Representatives of educational institutions and professional associations.
4. Health administration: current and future issues (the Delphi results).
5. Summary.

SUMMARY OF FINDINGS

1. The role of the hospital as an autonomous institution is changing.
2. Increased regulatory control and expanding intervention by external groups is causing increased complexity within the hospital.
3. The administrative role will involve more external "political" contacts with legislators, community groups, and agencies external to the hospital.
4. Community needs must be the inspiration for hospital policy formulation.
5. The health services administrator will become more of a resource manager for the community in the future.
6. Hospitals will need specialization and will need to develop alternative service formats.
7. Multi-hospital systems are one possible strategy for dealing with future changes in health care.
8. The image of the hospital will evolve into a center for health care and community health education, which will in turn involve the marketing of hospital services.

9. Ambulatory care developments and a resultant need for administrators will be important issues in the future.

10. Horizontal and vertical integration of health services are two means to deal with the increasing complexity of health services.

11. Delphi respondents anticipate major changes in cooperative decision-making, alternative delivery systems, and development of a public utility model for health care.

12. Delphi respondents generally agreed that governmental control, management delegation, and administrative specialists are increasing.

13. Major skill areas identified included: financial acumen, coordination, human relations, external political knowledge, communications, strategy, marketing, planning, and analytical and negotiating skills.

THE HOSPITAL ADMINISTRATIVE PERSONNEL INTERVIEWS

Interviews were conducted with hospital administrative personnel in the North Central region. In the hospitals, the chief executive officers were interviewed, as were other personnel in approximately one-half of the institutions. Generally, these were associate or assistant administrators, although in some cases the medical director or president of the medical staff was interviewed together with a specialist in areas such as finance or personnel. A small number of board members were also interviewed.

Chief executive officers were selected using a nomination process. Knowledgeable people in each state were contacted, such as the State Hospital Association's executive director and educational program directors or program faculty. The result of these nominations indicated certain chief executive officers who were acknowledged as leaders in the hospital industry within a particular state. Most of the nominees were with major hospitals. In certain instances, it seemed appropriate to add smaller hospitals so that we had a more representative coverage of administrative practices. Thus, approximately one additional hospital was included in each state in order to insure this broader coverage. Many of the people making the nominations indicated that it would be useful to include representatives from hospitals which had some problems which were being resolved by the administrators. In some cases, these were "inner-core" hospitals, and in other cases they were hospitals which had previously or were currently having financial difficulties. All of the interviews were open-ended discussion type interviews. Most of them were conducted at the hospital, although a few were conducted at Association meetings.

The Changing Role of the Hospital

Numerous changes were noted by the interviewees; however, major themes did seem to exist across interviews. Some of these themes included concepts such as the following: the autonomous hospital is dying; the scope of health care is expanding beyond traditional in-hospital care; specialization is increasing; quality patient care is more strongly emphasized; the influence of external groups has greatly expanded; the administrator's role has changed tremendously due to changes in the hospital and external forces; the image of the hospital itself is changing to become a center for health care and education; the interpretation of regulations from federal, state, and local levels is becoming more complex; employees are becoming more sophisticated in their requests and demands.

The role of the hospital itself is changing, so that the hospital as an autonomous institution is dying. The individual hospital will most likely be incorporated into a larger health system corporation which would combine education, patient care, preventive medicine, and research activities--health care delivery in a board sense of health care activities. The capabilities of hospitals have grown greatly; the hospital is now playing and, in the administrators' minds, will play an even larger role in the total health picture of the population.

Specialization in medical care is still on the increase, and has caused certain problems. First is the delineation of physicians into sub-specialties; that is, the surgeon is no longer just a surgeon but rather a specialist in some particular form of surgery. A second problem is the increased cost of supplying the specialized medical areas; a third problem is the additional manpower, additional equipment, and increased administrative needs of specialization. A fourth problem is the difficulty that a chief executive officer has in keeping current with developments in the medical field.

Quality patient care was consistently emphasized as a major concern. Patient care is thought of as existing outside as well as within the hospital. A major growth and change area is in ambulatory care facilities, emergency care, and other forms of walk-in health care services. The role of the hospital in health delivery has expanded, and is likely to continue expanding; this past and anticipated expansion is causing changes in the role of the administrator.

Institutions in the health care industry will respond to a broader range of health needs. Hospitals will continue to care for the ill, but in the future will provide services related to the prevention of illness and to community health. Thus, the hospital is expected to take a broader role, but funds to perform these larger functions have not increased to match such expectations. Some interviewees noted that hospitals are facing hard times ahead, and some institutions will face crisis situations related to financial issues. The theme of a health care system was heard continually. More sharing arrangements will be necessary in the future, and more of an open systems arrangement will be the norm. The traditional focus was internal to the hospital with little attention to external situations. Now, hospitals must be viewed in a systems framework with the system itself undergoing change.

The Influence of Groups External to the Hospital

The influence of external groups, such as federal, state, and local planning agencies, the PSRO's, third party payers, medical societies, employee groups including unions, minority groups, the general public, and rate control boards, is increasing. Also mentioned as significant external influences were the price freeze of several years ago, physician involvement in functional operations, pressures from patients, the city or community council, and other community groups. Large hospitals have definite effects on their community, especially when situated in residential areas or in smaller communities. In such a situation, the hospital increases congestion, brings a different type of person to the area often unlike the local resident, and thus may cause neighborhood people to be somewhat unhappy with the hospital. Some hospitals are located in deteriorating inner-core areas of larger cities where few improvements have been made, while in other cases, real changes have occurred in the inner-core areas around the hospital. In any event, administrators consistently noted direct involvement and concern with their surrounding community and neighborhood.

During the last 10 years, the intervention by outside agencies in hospital affairs has increased drastically. The burden of this intervention is significant, has added to costs, and has had a major impact on the operation of the hospital. A consistently mentioned concern was the tremendous amount of paperwork relative to outside intervenors in the hospital. Because of increased pressure from external forces, administrative staffs have been expanded. These increases in outside pressures have been harder on the small hospital than on the large one. A number of administrators felt the increased outside intervention was useful because some hospitals have not paid adequate attention to external concerns. These changes may be favorable if one perceives social responsibility to be an important role of hospital administrators. Many administrators, however, viewed outside intervention with dismay and wondered when it would end.

Increased Regulatory Control

In the past, the principal control agency for hospitals was the Joint Commission on Accreditation of Hospitals. Now, in addition to the Joint Commission, there are federal review processes to qualify for Medicare and Medicaid; many states are developing review programs; and Blue Cross/Blue Shield exercises a review process for rates. In general, since the Medicare bill of 1965, there has been increased governmental intervention, and hospitals now contract with governmental authorities to a much greater degree than ever before.

The interpretation of regulations at the state and local level presents a key problem for administrators. Many of the rule makers and people making interpretations of rules at these levels may not adequately understand the hospital setting. In addition, the public has in recent years expected higher quality services, yet is greatly concerned about costs. The importance of the various control groups reaching agreement on similar interpretations of their rules was a frequent theme. Some administrators expressed concern that governmental programs will have a dehumanizing effect on the hospital and that the multitude of rules and regulations will cause a lessened interest by the hospital staff in patient care, and in turn, poor patient care will result. The National Health Planning and Resources Development Act, Public Law 93-641, will have a great impact on hospital administrators, as it combines planning and regulation. In fact, it may have an equal or greater impact than Medicare or Medicaid. Control may be taken from the hospital in terms of cost lock-ins and also increased attention to planning by external groups. A concern is that decision-making must be shared with, if not totally taken over by, the planning agency. Yet, planning agencies do not have direct operational responsibilities for the hospital.

Generally, the change in the administrative role has come from an increase in complexity of the hospital resulting in the role of the management team in the hospital growing significantly. External activities in the community as well as internal operations of the hospital demand attention. The administrator must be pro-active in bringing the hospital system and the health system to the public. Administration has changed from crisis response to planning for future needs. A number of large hospitals are dealing with this changed administrative role by identifying one individual as an internal administrator and another as an external administrator. From an internal point of view, much of the action in the hospital focuses on the nursing floors. The person near to these activities has a good understanding of the internal functioning of the hospital. There is a definitely increased attention to outside activities and community representation for the chief executive.

Potential Administrative Strategies

There are three administrative strategies open to the hospital administrator: 1) protect the hospital and its operation from external influences: 2) non-activity--that is, do nothing but sit tight; 3) a pro-active position in terms of communicating the needs of the health system to its various publics, explaining these needs and the necessary changes. The third strategy appeared to be the most popular.

Administrators need to be more management oriented--not merely passive individuals. Hospitals need to market their services and to change the image of the hospital from a place to be avoided to a center for health care and community health education. The role of the administrator as builder is outdated; rather, he must be concerned with cost containment, utilization and conservation of resources, community involvement, and sharing of services among health institutions, and perhaps even be involved in the political process in terms of contact with legislative groups and rule-making groups. Many programs are administered by state offices such as rate review, health planning, need certification, and so forth. Thus, politics and health care may no longer be entirely separated. Administrator involvement at state and federal legislative and administrative levels is one way of shaping health care laws and rules and influencing the range of services that will be available.

The Corporate Form of Organization

The experiences of industry were often cited as useful in the movement of hospitals toward a corporate form, as was the utilization of various specialties in administration. Business may provide ideas, techniques, and models for health administration. A modern hospital structure may include divisions related to the service functions, the medical functions, and the administrative support functions. A small minority of administrators felt a formal corporate structure had little to offer the hospital, probably because their hospital was already functioning uniformly in a corporate manner.

The public utility model raised many concerns related to the idea that the health industry is being pushed toward a public utility concept. In fact, some states have utilized that model with a formal commission for setting hospital rates. Opinion of the public utility model was fairly mixed. Some felt rates would be fairly set and that the public would be comfortable with a utility model. Others objected to the utility concept, noting that this would be another regulatory body. Clearly, the role of the administrator is changing as the role of the hospital, the variety of external influences on the hospital, and the organizational model all undergo change.

Changing Relationships Among Staff

The relationships among administrative staff personnel were an area of concern including distinctions between specialist-type positions, such as financial managers or personnel managers, and more generalist-type positions, such as assistant or associate administrators. There was general agreement that better educated and better trained personnel for administrative positions are being produced, and that chief executives should be generalists. Administration may be too passive a term to describe what is needed in the health care field at the present time. Health care management, rather than health care administration, should be emphasized, in that management implies a more active stance than passive administration. Such a management role requires an unlimited commitment of an individual's time and a strong need for achievement in the individual manager.

Management in health care is becoming similar to managing any other institution of similar size because of the various environmental forces facing the manager. Hospital, as well as industrial managers, face cost issues, unionization issues, planning issues, and issues dealing with the environment and the community. Management skills may be transferable from one setting to another, especially for staff specialties, such as finance or personnel. However, for the generalist health care management position, the best career path may be to find a beginning position in a medical center or an ambulatory care facility. Broad exposure to health management problems could be gained at this level. Beginning as a specialist in, for example, finance or personnel, might be a detriment if one wished to eventually become chief executive officer. One concern was that specialists retain their particular view of the world and do not take a generalist orientation.

Specialists are more involved in the management team than they were in earlier years. There is an increased need for specialists in the hospital in such areas as finance, personnel, public relations, marketing, and planning. The specialist is becoming more sophisticated, perhaps due to the increasing complexities of the hospital environment. The controller has moved into the position of financial manager and away from working closely with the bookkeeper. The personnel director is becoming a human resource manager and not just a hiring specialist. Public relations people now handle most media contacts, while in the past these were handled by the administration. Unlike the past when the administrator "ran his own show," today he/she must depend on specialists and use an administrative council or management team approach to gain support and information for decision-making.

The specialist will probably play a much broader role in the future, especially at middle management levels. Where there is a high emphasis on technique and technical skills, the specialist background will be especially important. Specialists are becoming more involved in line management activities than they were in the past. Some suggested that specialists would perhaps best be hired from industry rather than seeking a person with a health services degree in a special field. Others noted that few health services programs were producing specialized managers and again recommended recruitment from industry. Specialists may have more job security, be more likely to rely on their specialty, and thereby not develop into general administration persons.

The development of more specialists is one area of changing relationships. With a trend toward hiring more specialists, the ultimate role of the administrator-specialist in the hospital is unclear; however, the specialist role is and probably will continue to increase. Generally, specialists are being included in management teams and management committees. Specialists appear to be viewed increasingly as members of top management, and the administrator must depend upon specialist skill areas.

Strategy Development Relative to Environmental Changes and Expectations

As far as hospitals are concerned, survival is the name of the game. The manner of survival varies greatly from one hospital to another, given the many different available strategies. At the center of most strategies are changes in the role of the administrator, changes in the consideration of financial matters, changes in the relationships among hospitals, and changes in dealing with government bodies.

Recently, the administrator has been fairly committed to financial activities. In addition, administrators frequently delegate many of the internal operating responsibilities to an operations officer such as an associate administrator. Another crucial development stemming from the environment is the need for more fiscal planning. Inflation and increases in capital costs have pushed costs up, and there appears to be little possibility of lowering such costs.

The need for cost benefit studies and planning is especially important. Productivity concerns are evident in the thinking of many administrators, and systems analysis appears to be one prominent strategy for dealing with environmental changes. Measuring productivity in nursing, housekeeping, and the emergency room was a frequently noted area of concern, but productivity measures have not yet been fully developed for the hospital industry. A key problem for the hospital is that a substantial part (perhaps 75% of its costs) are employee payroll costs.

Cost accounting concepts have only been applied to hospitals very recently. Hospital costs need to be categorized as controllable or uncontrollable, with cost centers developed so that organizational relationships can be more closely examined. It is hard to be administratively innovative and, at the same time, control costs in areas such as materials management, accounts payable, accounts receivable, and internal auditing. Pre-admission work-ups are one area where cost effectiveness could be improved. Considering direct and indirect costs in terms of cost control, achieving a "profit" position on a yearly basis, breaking even operationally, making provisions for funding depreciation, and financing new services were all concerns.

Competition between and among hospitals was viewed with mixed feelings.

Overall, inter-hospital competition should probably be downplayed so that good group relationships and group decision-making can occur among hospitals.

Hospitals need to work together in group action. One strategy for interaction is meeting together in district meetings or through hospital associations. The combination of voluntary and public sector hospitals is slowly beginning. Community hospitals, voluntary, and religious hospitals must work together so that each can learn from the other.

Multi-hospital systems are one possible strategy for dealing with future changes in health care. Such multi-hospital systems may take many forms, including actual physical mergers which would facilitate economies of scale. Chains or holding companies with multiple hospitals could be more efficient and more effective delivery systems. Simple sharing of services, such as laundry facilities, to entire hospital organization mergers are two extreme forms of group action. Horizontal and vertical integration with common equipment and personnel, and higher utilization, were often repeated themes.

Another major type of strategy for dealing with the environment involves the management contract arrangement in which a central hospital manages other community hospitals, providing consulting services, in-service education, and other services to satellite hospitals. This form might alleviate some of the difficulty in developing shared service programs because boards and administrators are often not truly interested in supporting shared service concepts. Yet, this arrangement reduces the duplication of services and congregates specialists of medical and administrative areas together in one unit where higher quality work can be developed.

Hospitals face the need to plan now more than ever, especially with increasing cash flow problems. Administrators must determine where the hospital is heading in the future. Emphasis should be on policy planning, on relationships with governmental agencies, and relationships with third party groups external to the hospital. Planning for expanded facilities must be executed especially well to prevent overbuilding. The planning director himself must work to convince key individuals that his views are valid and worthy of being considered.

Hospitals need to be more creative about how patients enter their systems. Concerns over patient mix in a fiscal sense appear especially relevant to administrators. Hospitals that are becoming overly dependent upon publicly supported patients find themselves in increasingly difficult financial straits.

Major changes in health care delivery systems are occurring because of environmental changes. Among these major changes will be the development of new forms of health delivery systems and new methods of entry into the delivery system. Examples might be the development of outreach programs, or the establishment of satellite clinics in underserved areas. Another potential change in the structure of hospitals will be the joining together of medical and administrative personnel in handling duties rather than one or the other being dominant. Some hospitals are considering profit-making holding companies because there are limitations in the non-profit corporate form which prevent the hospital from engaging in certain kinds of activities.

The Department of Health, Education, and Welfare's Forward Plan for Health, the influence of various local, state and federal governmental interests, and the influence of planning generally have all had an impact on the hospital.

In some administrators' minds, the environment of the hospital is in turmoil today. That environment requires care in understanding it and well planned and well thought out responses to the environmental changes.

New Skills and Requirements

About one-half of the administrators identified financial acumen as a critical skill area. As one administrator put it, there has been a shift in the emphasis of the three M's--manpower, material, and money--to more emphasis on the money or fiscal aspects. Part of the skill in finance will be in terms of financial planning. The administrator does not necessarily have to be an expert in finance, but he must have excellent interpretive skills and be able to converse with the specialists in the area of finance.

The need for skill in coordination continues as it has in the past. Of equal interest was the emphasis that was placed upon skills in human relations and working with other people. Some administrators felt that the human relations skills have become more important in the hospital today due to the fact that there has been an increase in the management philosophy of "Let us work together," rather than the autocratic philosophy, "I will tell you what to do." The professional manager should be aggressive, should be well informed, but also should be discrete. He needs clinical skills in determining problems in human relations, but he must base his solutions and certainly the analysis of these problems on an understanding of the human nature of people.

Several new skills were identified that the administrator ought to have. Among these was the ability to play the external political role--that is, the need to understand the nature of political leadership and determine appropriate kinds of behavior and concepts relative to changes in government and governmental officials. Internal political ability certainly would continue to be important, but added to this was the knowledge of external politics with which most administrators were unfamiliar.

The administrator has to become more skilled in communications in order to deal with environmental influences, such as the community planning council, pre-payment groups, labor groups, and patient advocate groups. He needs skills in determining and developing his sense of accountability and skills in identifying key people and helping these people set objectives for themselves. The administrator must be a good salesman and a good listener as well.

The administrator will have more data to deal with, and therefore needs analytical skills, as well as skills in dealing with data processing personnel. Quantitative skills are only one part of the general development of the chief executive officer, but they certainly are important. An analytic mind is necessary in order to analyze trends and to determine the direction the hospital should take in these kinds of situations.

The administrator should have a knowledge of strategy. This knowledge of strategy is not to be thought of in terms of Machiavellian politics, but rather in terms of identification of options. The manager should be active, innovative, and creative. Chief executive officers have to take an initiating role to an increasing extent. They must engage in creative thinking.

The manager of hospitals today must become more marketing-oriented. He must initiate marketing research and try to learn more of patient and community health needs. Marketing activities are an important function of today's hospital and these skills will be more important in the future.

Of increasing importance is the impact of planning activities. The administrator should be an expert planner. He must be prepared for emergency situations and he must be forward thinking. Planning today is a vital administrative function. In addition to this, planning skills will help the administrator understand agencies such as the local planning council or similar groups.

The administrator of today and tomorrow will need negotiating ability. In part, this comes with the increased possibility of labor unions and also with the changing nature and demands of employees. In addition, negotiating skills will be needed in dealing with the external environment.

Administrators of today have had to learn and develop tolerance for conflict and ambiguity. They often have to make decisions with less than 100% information. The administrator must be aware of and be able to handle a great deal of tension. He must be able to withstand pressure.

These skills were identified as being increasingly important today. One cannot help but be impressed with the additional kinds and numbers of skills. However, basic to these are still the business kinds of skills and the internal operating kinds of skills that administrators have required in the past.

INTERVIEWS WITH PROFESSIONALS ASSOCIATED WITH HOSPITAL ADMINISTRATORS EXTERNALLY

This section summarizes a series of interviews with professional personnel who were associated with hospital administrators in agencies outside of the individual hospital. Within the context of a role model of behavior, the focal person or actor has the central place in a network of role relationships.

This network is often referred to as the "role set." For this study, the focal person is the administrator in health care delivery organizations, primarily hospitals. The hospital administrator role model (see Chapter III) shows the hospital administrator as the focal individual who has certain perceptions of his role, and who engages in behavior directed toward goal attainment.

Interviews were conducted with representatives of state planning agencies, local planning agencies, PSRO organizations, HMO-type organizations, and Blue Cross organizations. The individual interviewed generally was the chief executive officer or his or her direct delegate in a particular organization. Interviewees were selected in essentially the same way described in the previous section for administrators. All of the interviews were open-ended discussion-type interviews.

What was striking about the issues raised by the interviewees, was the broad range of concerns beyond their own immediate domain, and the fair degree of consensus which seems to exist on a number of issues regarding the future role of the hospital administrator. These issues have been divided into a number of broad categories for the purposes of this report.

The Changing Role of the Hospital As An Institution

Public feeling toward the health care system is mixed. Some interviewees noted that both government and health care professionals are suspect. Thus, the consumer wants involvement in decision-making. Health care as a field appears defensive, low in initiation, and more disposed toward the protection of regulations versus the provision of options within the system. Hospitals should teach the consumer to accept reasonable responsibility for his or her own well-being, rather than to rely on the system.

There is a movement towards regionalization of health care and administrators must recognize that any one hospital is a part of a broader health system. Changes to the system must work with both the hospital and the physicians if such changes are to be effective. Few hospitals have combined medical group practices or ambulatory and primary care. Hospitals would be a natural setting for the development of HMO's, but hospitals are often not willing to develop an HMO relationship.

A new system is needed which relates hospitals to each other. Hospitals may well move toward a public corporation of an interdisciplinary type. The hospital could be the administrative center of the medical care system, but a key problem is how to implement such a major change. Mergers may not be the answer; as an alternative, perhaps, policy should be set at a medical center level, and hospitals should become operating centers. Alternately, various health care facilities could be gathered on a common campus-type arrangement to provide services to an entire community, or consortiums and affiliated arrangements could be worked out to integrate different levels of health care.

There was substantial agreement that the role of the hospital was changing and would have to change more in the future, due to expectations for public effectiveness as well as operational efficiency. Hospitals today need a different purpose than mere expansion, since not every hospital can be a major medical center. Only so many different facilities are needed. Hospitals will need specialization and will need to develop alternative service formats. Hospitals might well become the focus of the other health services available in the community, and will likely increase patient education regarding what is good health. Tertiary care hospitals should be expected to serve people in areas where service is poor, not available, and so forth, providing needed community services. Hospitals were not seen by these interviewees as generally initiating changes, and some suggested that prodding must occur from outside the hospital. Business and community leaders were seen as individuals urging change in the hospital setting. The sharing of equipment and personnel and the marketing of hospital services were two other areas noted in regard to the changing role of the hospital.

The problems of the hospital as a monopoly institution, the willingness of hospitals to work together to combat outside forces, and their unwillingness to engage in joint planning were areas of concern. As monopolies, hospitals need scrutiny and outside concern about their policies. Hospitals may very well be required to provide services requested by the community, regardless of their own philosophical base. The hospital itself must undergo an extensive period of change, in terms of more recognition being given to health care functioning as a total system and to particular changes in the role of the hospital as a focal point of that system.

The Changing Role of the Hospital Administrator

Just as the health care system is changing, requiring changes in the role of the hospital, these changes in the health care system necessitate changes in the role of the health care administrator. Administrators are now operating in a different health care system, and, if care is not exercised, they will lose a perspective of the whole system. There may be much provincial thinking on the part of hospital administrators, and the administrators' concept of relevancy must broaden. If living and working conditions and personal motivational factors affect health status significantly, then these must be taken into account in plotting the course of the hospital, along with typical hospital medical activities. Administrators should attempt to develop new services to meet the needs of the people, and should bring the hospital and ambulatory care together again. Administrators must focus on the role of health planning, be cognizant of HSA's and cooperate with them. However, hospital administrators are seen as not interested in planning, and, in effect, as having an anti-planning attitude.

One critical need is for better management. Hospitals, with some exceptions, are not managed aggressively, but greater professionalism is entering the hospital administrative system. However, the hospital administrator often is caught in the middle of internal forces, such as a board concerned about finance and a medical staff interested in new services.

Changing Goals of Administrators

In the past, the objective of the chief executive officer has been to support his facility. To some extent, this has resulted from the need of chief executive officers for mobility, and the desire of the chief executive to do nothing to damage his potential mobility. Increased beds, bigger buildings, and advanced technology are no longer satisfactory. New incentives are needed in terms of health care concerns and not parochial issues. Some interviewees suggested that administrators might well be licensed in the future, but others said it was very difficult to provide licensure or evaluation by outside agencies. Possible new goals may well be community health service, cost effectiveness, and ability to analyze and discuss pertinent data.

The goals of hospital administrators appear to be changing. A major problem for the executive in the future will be balancing cost control and high quality care. It is false to think, however, that good management is incompatible with high quality care. The evaluation of a hospital chief executive officer should be in terms of utilization of facilities, rather than growth. He must administer quality for productivity, rather than size. Hospital administrators at present seem to focus on hospital relations and physician satisfaction, but they have paid less attention to cost issues and profit and loss issues in running their institutions. The administrator of the future must keep his overall goal perspective clearly before him and develop information systems and data management techniques to address the overall goals of the organization. He must be able to use his resources for decision-making regarding people and materials.

Important goals for administrators include such things as how to expand their organizational base and how to relate outside the hospital institution. The need for management modeling as well as simulation studies is critical. A number of interviewees felt that too little research had been done in defining the proper role of the hospital administrator, and that there were insufficient numbers of skilled administrators to meet the likely increasing demands for health care administrators. A major activity of the chief executive officer might be to interest more young individuals in health-related careers.

Administrator Role Changes

Specific role changes for the hospital administrator include the need for aggressive management, willing and able to exploit the economies of scale on an inter-institutional basis, and the need for confidence and a willingness to take risks. Resistance to change is a problem for health care administrators, as well as many other health care workers, including physicians. More attention to organizational patterns by administrators is another critical role demand. There is a definite need to rethink the position of the hospital administrator as the position increases in complexity. It was suggested that many people will be trained for administrative positions, but few will be really good enough to fit the positions that will be open in the future.

The chief executive position in the hospital is a high tension position, with many role senders focusing on the position. With so many people to please, there are few secure administrators. The day of the administrative dictator has long gone, and the administrator must now be accountable for his or her actions and those of the staff. One major area of role change producing tension is the area of patient rights.

Both administrators and physicians have difficulty in understanding why a patient acts one way as a patient, and may act quite differently as a consumer. The consumer is likely to be more vocal and also to raise discernible questions. The traditional patient does not do this. Administrators may well end up in the middle of the patient complaint process as more people believe that medical care is a right. PSRO personnel noted that administrators are too permissive to doctors, and don't provide enough in-house supervision. This situation may, in the future, lead to an alliance of the PSRO personnel and the hospital administrator as they strive to change medical practice. Much is made of patients' rights at this time, but an equally critical area of impact will be employee rights with recent changes in the collective bargaining legislation.

Developing trends for the future are expected to be different than those of the last 35 years. The opinion was voiced that there was not really anything new in the hospital administration literature since 1940. In the future, however, the role senders anticipate that the competitive aspect of hospital management will be changed, and the administrator will become more of a resource manager for the community. One critical area of concern for the chief executive officer will be in physician recruitment, since physicians will likely continue to have control over the hospital's ultimate resources of patients. However, good physicians desire to be associated with effective hospitals.

External Orientation

A regularly recurring theme was that administrators would have to become externally-oriented--outside contact persons rather than operating executives. In the past few years, changes have occurred which have made the chief executive officer much more concerned with external relationships than internal relationships. These changes will probably continue. The chief executive officer will have to make judgments regarding his course of action in light of a great many different interests which will demand his attention. He will have to be a more effective decision-maker and have many more data points at his fingertips. A critical future role will be that of time and resource allocator.

More cooperation of each administrator with his colleagues and with his board members will be critical in dealing with external groups. At present, collective action by hospitals is weakened because many able administrators do not participate in such activities. At least some administrators in larger hospitals are willing to be critical of the "head-in-the-sand" attitude of many of their fellow hospital administrators. These administrators of larger hospitals may be able to push small hospital administrators into collective action, provided it is not merely defensive.

Because of the demands on the chief executive's time by outside relationships, the second in command will often deal with internal operations. Unfortunately, many chief executives may not be really equipped to handle the external contact function themselves. Thus, a different selection process will be necessary to find administrators who may play this external contact role, involving the political context of the chief executive's job. This political context refers to dealing with, negotiating with, and communicating with agencies and individuals external to the hospital. The future administrator must be a public relations-community contact person to handle these "political" demands. Along more traditional political lines, some role senders suggested that lobbying must occur on a one-to-one basis to be effective and that administrators will have to call upon their legislators directly, as opposed to having associations represent them.

Another aspect of the external role of the administrator is dealing with the community advisory groups, and with the public as a major influence on the hospital. Open public contacts will be the new rule, and administrators will no longer be able to keep their activities secret from the public. All in all, the administrator will have to be far more knowledgeable and more sensitive to the community. Planning will become a key part of the chief executive's job, and he will need to understand more about the planning process, rather than depending upon consultants. Finally, the future hospital administrator must understand what is happening in the whole field of consumerism and the implications that these events have for both hospitals and the planning process.

Changing Role of the Administrative Staff

The role of the administrative staff is also likely to change in the future. The problem of administrative talent was raised as an issue. Metropolitan hospitals can easily obtain qualified administrators, but small town, rural, or "downstate" hospitals have difficulty in recruiting and retaining qualified administrative personnel. In general, few administrators have strong back-ups or department heads trained in getting work done skillfully through other people. Thus, participation in decision-making is often low, but participation in decision-making can ultimately lead to real authority for the hospital administrator in that authority must come from the bottom up. The administrator, to be successful, must understand and gain the respect of his specialists. The administrator's real authority in the hospital can come from being the integrator of a great number of diverse people and elements in the health care setting.

Hospital organizational structures often provide the informality that specialists want. Lines of authority are vague, many decisions are made through committee processes to engender consensus, and oftentimes the individual specialist is the only truly knowledgeable person in the institution regarding a particular decision. Comments about specific specialized occupations were infrequent, but some felt that the hospital administrator may need a planning person on his own internal staff to facilitate communication with planning agencies.

Medical Staff Relationships

A number of comments were made about medical staff relationships. The medical staff may very well view the hospital as an abstraction, and the administrator as a source of unwelcome restrictions. It is fairly typical that administrators cannot control their medical staffs, according to some interviewees. In addition, efforts to educate the medical staff regarding the mutual interests of management and clinical services are not always successful. One problem for administrators regarding physician-administrator friction is that, while a board will ordinarily back the administrator, at the margin the administrator is expendible while the medical staff is not. When the administrator is not effective, the doctors end up running the hospital, but oftentimes the doctor is not as responsible as he needs to be for management. The future administrator needs to get the doctor involved as a partner in the management of a hospital.

Board of Trustee Relationships

A number of comments were made regarding the role of the administrator and the governance function. The development of a corporate board as a policy-making entity, with the hospital administrator as president of the board, may be desirable. Such a structure may build corporate responsibility and accountability which is important for the health industry. Unfortunately, many people do not understand governance. Most hospitals and their board members are now relating more to consumers and are more willing to supply data for external decision-makers. Still, however, too often the information the board itself receives from the chief executive officer consists of very minute problems, rather than major policy issues. Chief executives need to give boards very broad studies of major items or changes in the function of the operation of the hospital.

Issues Facing the Health Care Administrator

A broad range of issues was identified by the role sender interviewees.

These issues focused upon general concerns about meeting community needs through the health care system, concerns over planning, concerns about costs, and about government regulations, as well as a number of other issues related to alternative forms of health care delivery.

A major issue identified by role senders was the need for administrators to be conscious of, and to have the consumers' interests in mind, in making health care decisions. Some interviewees suggested that the health field is seriously out of focus in addressing the health needs of communities. Administrators must ask themselves whether or not the hospital exists to serve patients or the community. The focus must be upon the health of the community, rather than merely upon disease and patients. Unfortunately, health institutions are geared more effectively to the technocrat than to the consumer. Health institutions are changing, however.

Some hospital administrators tend to see the consumer as the enemy, but administrators must realize that, without the health consumer, they can do nothing. Only with the concept of relevancy and acceptance of a community constituency can the administrator establish intelligent goals and objectives, and then from these can flow corporate planning and other management processes. Community needs must be the inspiration for hospital policy formulation. More and more equipment to do less and less for the patient has been the result of increasing technology. Administrators, however, must be aware of the community needs and the community desires for specialized programs for low income groups and for older citizens. To enhance community based decision-making, better data collection is essential; yet, few people seem to know what kind of questions to ask. A common data set for community decision-making is one important area of need.

Some felt that health care should be a right for every individual, but that the health community has not responded to this need to recognize health care as a right. Such recognition might lead to the regulation of distribution mechanisms, and mean redistribution of some health facilities and providers. In the next few years, administrators will become more interested in the community, because more involvement with the community will lead to support for the administrators' requests. More initiative in health education of the public will be undertaken, so that the public will know how to use the system to their best advantage. Demands for consumer health care education will increase substantially, and various organizations, such as the HMO and the PSRO, expect to have a role in this increased consumer education.

Finally, in terms of meeting community needs, administrators must be more proactive rather than reactive. The administrator must seek out opportunities as he or she finds them. Administrators should get together at the grass roots, and, if they did so, no one would need comprehensive health planning, but the implication seems to be that this grass roots administrator cooperation is not likely in the near future.

Planning for Community Needs

In the past, planning agencies have been voluntary agencies. The voluntary model of planning, using mostly persuasion, did not work and the new movement in planning is toward regulation. There seemed to be little doubt that politics affected many of the planning issues--politics both in the traditional sense of the term as it related to government, as well as the politics among and between administrators and agencies. Some of the interviewees expressed the view that planning is essentially worthless, and has not accomplished much of anything. The hospital community seems to get what it wants, regardless of the suggestions of planners. This was a unique view, however, and many individuals noted that health care administrators are now concerned with planning; nevertheless, there is great question over what sanctions will be available for those who violate planning regulations. A more typical view was that planning issues will be very important to administrators. The emphasis on corporate planning is needed because the penalties for poorly defined goals, objectives and accountability at any time is too light. Decision-making easily becomes lost and, in the past, hospitals have not focused their planning.

A major change in the health administration field recently was the advent of planning legislation and its impact on the community, which is really just beginning to be felt. A number of planning officials noted that they and their agencies believed strongly in federal policies of promoting the highest level of health attainable for each individual and for providing equal and reasonable care for all citizens. They noted that planning agencies would become the resource allocators and thus must develop a more systematic approach to planning and a broadened data base. A new climate for planning must be established. The adversary role between the hospital administrator and the planner must be done away with, and a more trusting relationship developed. Some planners expressed concerns about local home-rule issues versus the need to plan on a regional or statewide comprehensive basis. They felt that the initiative for planning should come from the local community and, perhaps, even be centered on hospitals.

In terms of the strategies of planning agencies, a number of planners talked of the need to establish standards and criteria in advance of decision making. The standards and criteria could be prepared by various groups, including medical personnel and hospital administrators. Then the various institutions could assess their own plans in light of the standards established by their peers. This need to specify the criteria for decision-making was emphasized by planning officers. Others noted that physicians must be brought into the planning process, and might even develop many of the standards which the hospital and other agencies would be required to live up to.

A problem is that administrators either do not have, or do not understand, the data base from which planning proceeds. Data can free the institution and the administrator from political influence, but this can only happen when there is an adequate data base. Area planning councils must insist that data be made available to them. Such data will likely be more available for planning in the future, and then the consumer will be able to judge proposed plans in an adequate manner. A future development will be that administrators will come together to collect the factual information to defend their long-range plans among themselves as well as before comprehensive health planning agencies.

Consumer input for health planning organizations must be increased because the success of the planning activity depends tremendously upon community involvement. Inputs to the planning council from its various constituencies typically occur through the board, yet the makeup of planning boards presents problems because of status issues and issues related to who should be members. Sub-area or more localized groups should be involved in the planning process. Involvement of businessmen and industrial leaders is important for the success of planning councils and the Health Systems Agencies (HSA). Public exposure of proposed plans and of the activities of existing facilities was emphasized. The need for comprehensive planning, including mental health planning, the need for more policy planning, as opposed to mere blue-print type planning, and the need for health programs at the national and state level with specific objectives and resource allocations, all seem to be important.

Administrators will need to associate with HSA's to better understand the influence of the planning agency. The need for qualified staff is critical and some planning agencies may need more hospital representation than they have had in the past. There will likely be four groups of activities in the new HSA format. Group 1 will be the planning activity. Group 2 will involve review and comment functions, generally related to certificate of need programs. Group 3 will involve developmental funding or program development activities. Group 4 will involve the regulation function, in terms of the review of appropriateness of facilities and services. The new HSA concept will point the way toward the development of health care systems, but concern was expressed about the adequacy of funding for the HSA program.

Costs of Health Care

Concern was expressed by diverse groups about cost issues, but most frequently by those directly involved in paying for health care through Blue Cross type organizations. Cost increases in health care in 1975 were cited as increasing by about 17% while the general cost of living increase was only 7%. The financial survival of the health care system is at issue. Inflation and increases in capital costs lead to an emphasis on cost and rate regulation in the future, and the financing of health care will be more closely scrutinized. A PSRO role sender noted that his type of organization might be active in the next few years in scrutinizing policies which would increase patient costs. Other interviewees noted that new disposable supplies must be looked at from a cost-effective standpoint, rather than from a convenience standpoint.

One key problem in the financial area is the doctor. Cost containment and quality appraisal should involve a broader power base than the medical staff; it should involve the board, the administration, and the medical staff. Blue Cross has been advocating changes in medical practices, such as pre-admission testing, home care, surgicenters, and so forth, but it has not been as successful as it should be in encouraging pre-admission testing. Blue Cross benefits must be balanced in a reasonable way so that Blue Cross premiums will cover the benefits offered. In some areas, hospitals have been cancelling their Blue Cross contracts, and are resistant to any Blue Cross contract which would pay less than full charges.

Government Health Care Regulation

An important change in health care administration in recent years has been the increased role of government. Controls and bureaucratic actions which presumably interfere with freedom of choice and action are resented. It seems likely, however, that governmental intervention and regulations will continue and become more strict. As more data are collected, for example through PSRO programs, tighter policy and more restrictions may develop. Third party payers may also increase their restrictions on what they will pay for.

State governments sometimes feel by-passed by the federal government. The consumer is ultimately the person to stop the trend towards federalism and more restraints. This again requires that providers of care expand their opportunities to communicate with the public and get the public on their side. State level health agencies may eventually become the regulatory agencies for health care. Change of services and facilities, certificate of need programs, and mandatory rate review will likely be done at the state level, and sanctions will probably be administered at the state level.

In terms of the issue of governmental regulation, the hospital is no longer sacrosanct. It is vulnerable to legal suits and more health care policies may very well be set by the courts. Thus, few decisions are made without much care and thought. The critical issue again raised is the need to first look at the data base before establishing regulations or new laws.

Alternative Forms of Health Care Delivery

Alternative forms of health care delivery systems came up regularly in the role sender interviews. Different service modes are seen as necessary. Two major decision areas are the juxtaposition of economy versus technology. The central theme of any alternative delivery system will likely be preventive medical care. However, alternative types of services cannot be too radical in form or there will be difficulty in getting them accepted. The hospital may not be the center of preventive medicine developments because, according to some, the hospital is too narrow an organization to function in a real preventive medicine and education manner.

An important concern in developing new service and delivery systems is not to cause the downfall of the current facilities. What must be done rather, is to broaden the base of services of hospitals and nursing homes. Any of the extreme service alternatives would raise prices even higher in hospitals on a per patient basis if utilization rates were decreased substantially. It will undoubtedly be difficult initially for hospitals and other medical units to work together. If the hospital or other system unit is doing well, there does not seem to be any need to cooperate. If, on the other hand, it is not doing well, there would not be many system units who wanted to cooperate with the unit which was having problems. Nevertheless, the emphasis is moving away from acute care to alternative delivery forms. The hospital could be a developer of these alternative delivery forms. The shift from inpatient care to ambulatory care is one such alternative form.

Ambulatory Care

A definite movement toward ambulatory care is anticipated, with a resulting need for more ambulatory care administrators. Some HMO personnel suggested that ambulatory care ought to be the goal of any hospital administrator, and the hospital administrator should not worry about a bed census number. Physicians may play a lesser role once true ambulatory care administrators are developed.

The philosophy of developing hospital-based HMO-type organizations is attractive, but hospital physicians often will not allow such a program. A critical issue in the HMO concept for alternative health care delivery is the rapport between the doctors and the administration. The resistance to the HMO concept was often relatively low-key and below the surface. Local community and hospital support is important in establishing HMO plans, but it is not easy to arrange HMO programs because of initial resistance by doctors and hospitals. Some Blue Cross agencies are offering HMO-type programs which seem to be fairly well accepted. One Blue Cross official noted, rather proudly, that his own employees were enrolled in the Blue Cross HMO-type program.

Planning officials seem to be especially interested in ambulatory care with accompanying insurance reimbursements, yet changes in the health system must consider the employment impact on the health care personnel themselves. Alternative forms of health care delivery will undoubtedly change the need for various health professionals. These changes must be considered in the planning process.

Evaluation of Health Care

A major change in health care administration has been toward programs with quality assurance. The greater complexity of data and the increased data available require multivariate analysis. In the future, states may develop a data information system for PSRO's. Evidence is now gathering of extreme variations among different populations in surgical rates, post-operative mortality, and staffing ratios, but there seems to be an absence of outcome data. Hospitals may find it necessary to join together for evaluation purposes to enlarge their statistical base.

The quality of care is a central issue, but reviewing the quality of care has presented problems to PSRO's. More assessments of the level of care, the appropriateness, and the cost of providing care, will occur. Prolonging life was raised as an important issue, but one which could not be dealt with in an effective way in many settings. Prolonging life may be primarily an economic question, and not necessarily a medical or social question, according to some. In any case, the appropriateness, the level of care, and the quality of care are all difficult to define.

Again, the need was expressed for the development of standards for various service areas. Such review standards do not exist in many cases yet.

Review activities must be cognizant of union relationships because the review process affects the activities of employees. The slowness of the establishment of the PSRO system and the long-range need for more administrative personnel to work with PSRO's were noted.

REPRESENTATIVES OF EDUCATIONAL INSTITUTIONS AND PROFESSIONAL ASSOCIATIONS

This section summarizes a series of interviews with six educational and professional association personnel involved with hospital administrators. The interviewees included four in education-related roles and two state hospital association directors. Due to the small number of interviewees, their varied organizational backgrounds, and the need to protect interviewee anonymity, this section focuses on a synthesized broad-brush perspective of the issues raised, rather than upon issues applicable to any particular educational-association setting.

Increased Complexity

A key concept was the increased complexity of the health services administrator position. All agreed that the increased complexity came about from both external and internal forces acting upon health institutions, and especially upon hospitals. These changes, together with the need for more political and community involvement, have made the position of the hospital chief executive officer more complex.

By contrast, another interviewee noted that the increased complexity was really only apparent at the extremes of the chief executive officer position, and the typical activity patterns were not very different from what they had always been. He felt that the hospital chief executive officer is still concerned primarily with internal operations of the hospital and only partially concerned with external affairs.

Along with increasing complexity in the position of the chief executive officer has come increased accountability. Formerly, the chief executive officer was accountable only to his board, and, in some cases, to the community. Today, he is responsible to a variety of publics as well as to the board. The board itself is operating today under increased constraints. Its composition has also changed. For one thing, the administrator or chief executive officer is more likely to be a member of the board. The composition of the board should probably change even more--in the direction of more internal members of the hospital administration serving on the board.

The need for internal board members is accentuated by the trend toward utilizing the corporate form of organization in the hospital. This development has just started and it is problematical, according to some interviewees, as to its viability and development. The impression exists that the trend toward a corporate organizational form was not very well developed and perhaps not a trend at all, but rather just a passing fad.

Approaches to Meeting Increased Complexity

As is usual when complex changes are underway, a number of approaches develop to meet the changes. Organizational changes have occurred which have tended to resolve some problems but which have also created others. One of the significant organizational changes has been the "horizontal integration" of hospitals, in which a parent hospital operates a series of other hospitals. The chief executive officer works with various consumer groups, as well as providing a leadership role. Specialists in the parent hospital, such as those in planning, finance, industrial relations, and engineering staff provide managerial expertise to the affiliated hospitals.

Another organizational form has been termed "vertical integration," in which the parent hospital develops affiliations with different kinds of health delivery units such as clinics, ambulatory care, long-term care, mental health, etc. In other words, different "product lines" are involved. This form also permits a combination of specialists and related expertise as well as a means for developing cost-effective approaches through better utilization of facilities and personnel.

Both of these organizational types are to be found in the corporate form of organization. However, the role of the chief executive officer in either organizational form becomes one of over-all planner in order to meet external demands. This development often permits the utilization of more specialists, which tends to reduce the complexity of the chief executive position through delegation of some responsibilities to others.

Another approach to coping with complexity is the development of administrative specialists by the state hospital associations. Specialists in the areas of public and community relations, finance, computers, engineering, etc., are found in many associations, and can both educate the chief executive officer as well as permit him to better meet the increased complexities of the position.

A change is developing which involves the increased incorporation of ambulatory care into the hospital program by moving away from the independent doctor's office format. More full-time hospital-related physicians are serving as direct hospital employees, thus permitting a more integrated administrative approach and better cooperation between administration and the medical staff.

The chief executive officer has the potential to gather more power to himself through the control of information. As his position becomes more complex, some interviewees thought he would acquire more knowledge of external forces such as rate reviews, third party payers, HSA, PSRO, OSHA, ERISA, NLRB, etc. Few personnel in his organization have as comprehensive a knowledge, which focuses power in him. This situation may also mean that physicians will side with nurses to undermine the power of the administrator. Such a development would mean greater division and conflict of interest and, in turn, a more complex situation. The administrator may tend to isolate himself even more from other professionals in the hospital due to the external contacts' demands on his time. Whether or not these problems will develop is questionable, but the potential of greater power for the chief executive officer is possible through greater knowledge of both internal and external developments.

Another possible approach to dealing with complexity is the development of participatory decision-making, which is probably present more in theory than in practice at the present time. At any rate, the hospital chief executive officer and his administrative personnel may work more cooperatively with physicians and nursing staff to make decisions affecting hospitals. A potential problem is the time this approach involves but the time may be well-spent if it reduces conflict and tension. Many believe the team leader approach to be a viable form of participative decision-making.

Educational Aspects

Education, both graduate and continuing, as an approach to dealing with complexity and change, was proposed by all of these interviewees. One would expect this pattern to emerge, since all of these interviewees were engaged in education in one form or another. Yet, there was a wide diversity of opinions about the educational process--ranging from the view that the present state is excellent and should be continued, to the statement that there is a need for significant change in education for health services administration.

Concern was expressed over the initial selection of students for Health Services Administration programs. All graduate programs have more applicants than they can effectively educate. Therefore, some type of selection process is needed. The need for recruitment of students of high quality is also present. Some concern was expressed that with the use of "president," "chief executive officer," and similar titles, students who were interested in power, prestige, and high salaries would be attracted to programs rather than those primarily interested in health. Whether or not this is true, there is a need for recruitment and selection of well-qualified students into health services administration educational programs.

Once admitted, the student pursues a course of study which has a basic emphasis on administration, health, or some combination of the two. Programs located in business schools emphasize administration, whereas those located in public health academic units place the emphasis upon health. A trend seems to be developing, especially in those programs in business schools, for an emphasis upon a functional area of concentration. This concentration could be accounting, finance, industrial relations, engineering, purchasing, risk management, etc. The rationale behind this trend is that the student needs to bring some skills with him to his first job so that he can make some direct contribution to the organization as opposed to being solely in a training program, which is very expensive. Furthermore, many hospitals are becoming so complex that it is almost impossible for the inexperienced graduate to move into an assistant or associate administrative position and be effective without considerable experience. Some programs are resolving this situation by expecting students to have obtained some given experience level prior to entering the graduate program. The internship/residency still continues, but the debate is how to make this more meaningful to both students and the organization.

Health services administration programs potentially, then, have three major components. These are 1) the development of managerial skills, 2) an understanding of the health industry, and 3) an area of concentration. As was indicated earlier, the location of the programs in the university has an impact on the emphasis given to any one of these areas. A fourth educational program component involving general knowledge and understanding of society as a whole also appears to be important in the prospective administrator's background.

Several problems relative to health administration programs were identified by the interviewees. One of the problems was the unstable state of funding of many programs. In part, this was due to the location of the university but often was more likely due to peer relationships within the academic community. Concern was expressed about the type of research conducted if any was performed at all and the use of practicing administrators to teach courses. Many of these people are not well qualified to teach, academically speaking, and furthermore have other more important responsibilities than teaching. The result is often a course which relates the instructor's personal experiences in opposition to general theory and its application.

Another problem is to gather a sufficiently large faculty so that proper interaction can take place. All too often, the faculties are small in size, faculty members have joint appointments, and faculty involved have diverse specialties. These constraints and others result in inadequate time for planning, and especially for curriculum revision. Some programs are moving to problem-oriented teaching, rather than descriptive approaches. This change results in providing skills needed for the first several years in the field, as well as the ability to locate and solve problems when the student has advanced to a higher level of responsibility. The basic managerial skills may be the same, regardless of the type of organization. The difference occurs in the application of the skills to the environment in which the administrator/manager finds himself.

Many hospitals apparently do not really provide challenging positions to the new graduate. Thus, he is not motivated, and therefore does not advance. This problem may be part and parcel of the lack of a functional skill on the part of the recent graduate, and thus he cannot be assigned a position which has much challenge to it.

In a different but related area, much emphasis is being given to continuing education. There are many delivery models and no one is sure which is the best model. Some interviewees were of the opinion that graduate or college credit should be a part of continuing education courses. Others did not believe that this was really necessary. Opinions were expressed that continuing education should be problem-oriented and should relate to current issues as opposed to the future development of participants. All programs and professional organizations were participating in continuing education, some more successfully than others. All agreed that more emphasis should be given to continuing education.

HEALTH ADMINISTRATION:

CURRENT AND FUTURE ISSUES: THE DELPHI RESULTS

This study attempted to delineate the present role content and future role expectations of health care executives. This information is essential to understanding how the health care administrators' role is developing, and what the implications are for educational programs. No one, of course, can predict the future exactly, but there are several ways of looking at the future which can produce reasonably accurate estimations of what will happen over the short term. Strauss (1975), in her background paper for the Kellogg Commission on Education for Health Administration, used the predictions of several well-known futurists to delineate trends and countertrends in the socioeconomic, political, and scientific areas. She then combined these with her own perceptions to develop broad implications for health administration. This method has the advantage of utilizing the best thinking currently available, but still must be considered as one person's viewpoint.

Another frequently used method of looking at the future is to gather experts in a meeting and have them respond to a series of issues or position papers. This method was recently used by the Council on Research and Development of the American Hospital Association (Curry, 1977) to construct a research agenda on policy issues facing hospitals in the 1980's. Such meetings, of course, are expensive to conduct and may not result in consensus of opinion by the participants.

A recent innovation in forecasting is the Delphi method. As explained by Delbecq, Van de Ven, and Gustafson (1975), "Delphi is a group process which utilizes written responses as opposed to bringing individuals together." The basic Delphi methodology is to have individuals fill out a series of questionnaires. The first questionnaire poses a broad question, and each subsequent questionnaire builds on the responses to the previous one. The number of iterations can vary, depending on the degree of consensus or the amount of information exchange desired.

The forecasting method used in this study was a modification of the Delphi. Rather than a first questionnaire, the personal interviews conducted with hospital chief executive officers, their senior associates, and other health care administrators in the Mid-West were used to develop issues. Each respondent was then asked in the Delphi to make two judgments about each of the issues: a) How much they agreed or disagreed with the statement as it presently applied, and b) How much they agreed or disagreed with the statement as it would represent reality during the next ten years.

A scale of 1 (strongly agree) to 6 (strongly disagree) was used for ranking purposes. A mean rank was calculated for each statement to indicate group agreement or disagreement with each statement. The standard deviation was also calculated for each statement to indicate the degree of consensus within the group. Means, standard deviations, and ranks based upon mean scores are shown for all items in Table V-1. The Present and Future columns refer respectively to the agreement/disagreement that the statement represents reality 1) at the present time and 2) during the next ten years. The Difference column refers to the score obtained by subtracting future from present scores. A positive difference score indicates that the statement is more likely true in the future.

Current Health Administration Issues

For the group as a whole, there was a strong tendency toward agreement that the statements represented reality. Of the 35 statements presented, there was general agreement that 80% of them represented reality at the present time.

The statements that elicited the strongest agreement were (in rank order):

1. Governmental control of health services administration procedures is increasing.
2. Hospital chief executives are experiencing more conflicting demands on their time.
3. The hospital chief executive must understand the political process, i.e., policy-making or administration in government.
4. The role of the hospital chief executive in regard to the internal management of the hospital is involving increased delegation.
5. The number of administrative specialists (e.g., accountants, systems engineers, personnel managers, etc.) is increasing in the hospital.

As can be seen, most of these statements are concerned with the administrator's perception of his personal role and the pressures on that role from external factors, namely, the government and the local community. As the administrator perceives it today, the role is moving away from internal management and toward more involvement with external forces.

The statements which the respondents felt did not represent present reality also reflected external pressure. The statements eliciting strongest mean disagreement were:

1. The impact of proposed national health insurance is optimistically anticipated by hospital chief executives.
2. Physicians with administrative training are the most

TABLE V-1
HEALTH CARE ISSUES RESPONSE SUMMARY
(ALL RESPONDENTS)

	HEALTH CARE ISSUES	PRESENT[1,2]			FUTURE[1,2]			DIFFERENCE[4]		
		MEAN[3]	S.D.[3]	RANK	MEAN[3]	S.D.[3]	RANK	MEAN[3]	S.D.[3]	RANK
1.	For the hospital chief executive, involvement in making policy is becoming more important than administrative implementation of policy.	2.397	0.959	11	1.889	1.138	13.5	0.508	0.821	17
2.	The hospital chief executive is becoming the team leader of groups of administrative specialists.	2.161	1.027	6	1.629	0.945	6	0.532	0.762	15
3.	Governmental control of health services administration procedures is increasing.	1.635	0.703	1	1.206	0.408	1	0.429	0.560	23
4.	Alternative sources of revenues are being sought by hospitals to reduce dependence on revenues from short-term acute care inpatients.	2.790	0.908	22	1.790	0.908	9	1.000	0.747	4
5.	The number of administrative specialists (e.g., accountants, systems engineers, personnel managers, etc.) is increasing in the hospital.	2.095	0.911	5	1.683	0.997	7.5	0.413	0.613	24
6.	Health care delivery systems are developing which involve mergers or consolidations of acute short-term hospitals.	2.508	0.914	13	1.619	0.851	5	0.889	0.785	6.5
7.	The hospital chief executive must understand the political process; i.e., policy-making or administration in government.	1.841	0.865	3	1.238	0.560	2	0.603	0.708	13
8.	Hospitals are moving from an acute care orientation to a concept of total community health care.	2.730	0.987	21	1.841	0.865	11.5	0.889	0.844	6.5
9.	The initiative in comprehensive, integrated regional health care planning is shifting from hospital chief executives to health planning agencies.	2.841	0.971	23	2.064	1.162	18	0.778	0.870	9.5
10.	Competition between hospitals is being replaced by cooperative, joint decision-making to meet community health needs.	3.635	1.067	30	2.508	1.134	28	1.127	0.889	1
11.	Concern about cost containment is leading to an increased emphasis on developing alternative delivery systems.	2.984	1.024	26	1.937	0.896	15	1.048	0.831	2
12.	Consumer representation is becoming increasingly common in the hospital decision-making process.	3.274	1.074	29	2.468	1.097	27	0.806	1.022	8
13.	Quality control and evaluation of services offered are increasing in importance for the hospital chief executive.	2.175	0.814	7	1.683	0.839	7.5	0.492	0.738	19.5
14.	Physicians with administrative training are the most appropriate chief executives for integrated regional health care delivery systems.	4.262	1.109	34	4.295	1.295	34	-0.033	0.632	35
15.	The growth of integrated, comprehensive, regional health care systems is accelerating.	3.100	1.069	27	2.131	0.785	21	0.967	0.843	3
16.	Electronic data processing is providing more information to aid hospital decision-making processes.	2.318	0.820	10	1.841	0.700	11.5	0.476	0.618	22
17.	Responding to employee demands is becoming increasingly time-consuming for the hospital chief executive.	2.857	0.677	24	2.651	1.194	29	0.206	0.864	30

HEALTH CARE ISSUES	PRESENT[1,2]			FUTURE[1,2]			DIFFERENCE[4]		
	MEAN[3]	S.D.[3]	RANK	MEAN[3]	S.D.[3]	RANK	MEAN[3]	S.D.[3]	RANK
18. The impact of proposed national health insurance is optimistically anticipated by hospital chief executives.	4.548	1.141	35	4.323	1.400	35	0.226	0.999	28
19. The principal concern of hospitals is shifting from what is best for the organization to what is best for the patient.	3.733	1.039	31	3.250	1.348	31	0.483	0.892	21
20. Hospital fee and cost reimbursement systems are shifting toward a "public utility model" of rate base determination and maximum allowable rates of return.	3.113	1.073	28	2.097	1.036	20	1.016	0.914	3
21. Physician participation in hospitals' administrative decision-making is increasing.	2.694	0.898	19	2.403	1.108	26	0.290	0.818	26
22. The hospital chief executive is losing management prerogatives and control to external agencies.	2.619	1.054	17	2.079	1.067	19	0.540	0.591	14
23. Voting representation of the medical staff on the hospital Board improves physician--administrator relationships.	2.903	1.197	25	2.823	1.274	30	0.081	0.375	32.5
24. The business corporation is becoming the organizational model for hospitals.	2.581	0.915	15	2.210	1.203	24	0.371	0.891	25
25. The hospital is becoming involved in marketing health services.	2.677	1.128	18	2.016	0.983	17	0.661	0.829	12
26. The role of the hospital chief executive in regard to the internal management of the hospital is involving increased delegation.	1.984	0.729	4	1.492	0.592	3	0.492	0.693	19.5
27. The formal education of hospital administrators should be aimed at preparing management generalists rather than specialists.	2.222	1.114	8	2.222	1.385	25	0.000	0.967	34
28. Hospitals are developing the campus type organization with satellite clinics, management contract agreements, and long-term care facilities under one management.	2.571	0.756	14	1.794	0.722	10	0.778	0.683	9.5
29. Voting membership of the hospital chief executive on the hospital Board is becoming more frequent.	2.695	0.951	20	2.183	1.172	23	0.508	0.728	17
30. The hospital is playing an expanded role in health education for both the patient and community.	2.587	0.978	16	1.889	0.969	13.5	0.698	0.775	11
31. Hospital chief executives are experiencing more conflicting demands on their time.	1.809	0.644	2	1.587	0.638	4	0.222	0.490	29
32. The hospital chief executive has an ever-growing concern about his personal continuing education.	2.475	0.959	12	1.967	0.966	16	0.508	0.622	17
33. Health services administration is sufficiently unique such that only graduates from health service administration programs should be hired for administrative positions above the departmental level.	3.984	1.385	33	3.746	1.626	33	0.238	0.995	27
34. The residency in the education of health service administrators serves a necessary educational purpose.	2.238	0.962	9	2.145	1.006	22	0.081	0.581	32.5
35. Hospital chief executive positions are providing opportunities for their incumbents to work on tasks of their own choice at times of their own selection.	3.754	1.164	32	3.533	1.200	32	0.200	0.935	31

NOTES TO TABLE 1

[1] Scaling of Responses was:

1 = Strongly Agree

2 = Agree

3 = Mildly Agree

4 = Mildly Disagree

5 = Disagree

6 = Strongly Disagree

[2] "PRESENT" refers to agreement/disagreement that the statement represents reality at the present time. "FUTURE" refers to agreement/disagreement that the statement will represent reality during the next ten years.

[3] Mean and Standard Deviation (S.D.) based upon number responding to each individual item.

[4] Difference refers to the score obtained by subtracting future from present scores, i.e. Difference = Present - Future. A positive difference score indicates that the statement is more likely true in the future.

appropriate chief executives for integrated regional health care delivery systems.

3. Health services administration is sufficiently unique such that only graduates from health service administration programs should be hired for administrative positions above the departmental level.
4. Hospital chief executive positions are providing opportunities for their incumbents to work on tasks of their own choice at times of their own selection.
5. The principal concern of hospitals is shifting from what is best for the organization to what is best for the patient.

The strong disagreement with the last statement would seem to indicate that the administrators do not feel that the health care system is responding very rapidly to the external pressure for change. These statements evoking the least agreement from the respondents also show some rather strong feelings as to who is best qualified to administer the health care system and how that person should be trained.

Future Health Administration Issues

The administrators were asked to express their agreement or disagreement that the statements would represent reality during the next ten years. The general tendency was that if the interviewee agreed that the statement represented reality in the present, he was likely to say that he agreed with the statement even more in the future. Also, if he disagreed with the statement presently, he was likely to say that he disagreed even more so that it would represent reality in the future. It is therefore not surprising that the statements that showed the highest degree of agreement in the present were also the ones that showed the highest degree of agreement in the future. Similarly, those with which they disagreed the most in the present were also the ones they disagreed with the most in the future. The only addition to the list is the statement, "Health care delivery systems are developing which involve mergers or consolidations of acute short-term hospitals," with which they strongly agreed in the future.

Issues of Change

As was stated previously, if the interviewee agreed with the statement as it presently applied, he was very likely to agree with it even more as representing reality for the future. Whereas the statements which received the strongest agreement both in the present and the future were items relating directly to the role of the chief executive officer and his personal concerns, the statements which showed the most changes in position generally related to the health care system and the changes which would take place within that system. Those statements receiving the most changes in position almost universally moved from being disagreed with or bordering on disagreement to positions of agreement. The statements eliciting the most change were:

1. Competition between hospitals is being replaced by cooperative joint decision-making to meet community health needs.
2. Concern about cost containment is leading to an increased emphasis on developing alternative delivery systems.
3. Hospital fee and cost reimbursement systems are shifting toward a "public utility model" of rate base determination and maximum allowable rates of return.

4. Alternative sources of revenues are being sought by hospitals to reduce dependence on revenues from short-term acute care inpatients.
5. The growth of integrated, comprehensive, regional health care systems is accelerating.

The statements strongly agreed with, plus the statements showing systems changes in the future, would lead one to conclude that administrators do not feel the system has responded yet to the external pressures they are feeling as individuals. They do feel, however, that the next ten years will see some dramatic changes in health care delivery.

The least amount of change in position revolved around the statements concerning medical staff-administrator relationships and the education of the health care administrator. The respondents did not feel that physicians with administrative training are the most appropriate chief executives for integrated regional health care delivery systems presently, and they foresee no change in that position in the next ten years. They also feel that the administrative residency serves a useful purpose and do not anticipate much change in that position in the next ten years. In other words, they do not feel that anything that will happen in the next ten years is going to change their opinion of who should be running the system and how they should be trained.

Consensus of Opinion

The consensus of opinion among the administrators was measured by calculating a standard deviation for the mean ranking given each statement. As would be expected, the deviation was least on those statements on which all respondents agreed highly. The widest dispersion of rankings occurred on those items on which there was a high degree of disagreement. This means for those items with which the interviewees expressed a strong agreement, there was also a tendency for all administrators to rank them approximately the same. For those items on which strong disagreement was expressed, there was a wide range of opinion as to exactly where the item should be ranked. For example, the item having the strongest agreement had a mean rank of 1.6 (between strongly agree and agree). The item eliciting the strongest disagreement had a mean rank of 4.5 (between disagree and mildly disagree). This pattern was true both for present reality and for the future.

SUMMARY

This chapter has summarized the results of interviews with three different groups. These groups consisted of hospital administrative personnel, including the chief executive officer, professionals associated with hospital administrators externally, and representatives of educational institutions and professional associations. In addition, the results of a Delphi instrument based on the non-directive interviews with the three groups were reported.

Chief executive officers and other administrative personnel interviewed indicate substantial changes in health care delivery systems and health care management in the years ahead. Among these changes are changes in the role of the hospital itself, changes in the role of the health care administrator, changes in the roles of specialists within hospitals, changes in skills required, and an increasing complexity in the health care environment.

There was substantial agreement that the health delivery system of the future will be different from what it is today. Among these differences, some forms of combination, merger, affiliation, or consortia agreement seem most likely. Some such developments are already in progress, either through the development of management contract arrangements or through the development of satellite and outreach programs. The trend seems to be toward a central medical care unit with other outlying units serving as feeders to the central unit. More corporate structures and more multi-hospital chains likely lie ahead.

Another major expectation of the future is for more government involvement in health care. This may be in the form of federal rules and regulations, or it may be more state centered, but in any case, increased governmental interaction and intervention with health care institutions is foreseen. In general, more external relationships will involve the administrator, who will become the external representative of the hospital in his community. The fiscal situation of hospitals will remain relatively tight, and, if inflation continues, may become even more severe. Thus, cost controls, cost consciousness, and cost containment programs will become very important for the hospital manager. The climate will be toward more cost effective health care in the future.

The service orientation of the hospital and the need of the hospital to work with community resources will also increase. There will be more emphasis on the areas of community outreach and community relations. Health planning in relation to the community will become more important than it currently is. Administrators will have to be more involved in community health planning and become more proficient in this area.

The addition of more middle level administrative specialists is another expectation for the future. Sophistication and analysis capabilities in many areas will increase and the administrator will need specialized units to deal with these areas. In turn, the administrator probably will face greater tension than he had in the past, unless he can effectively delegate to his subordinates. Involved with this administrative specialization will be the increased frequency of hospital managers actually holding positions on their boards of directors, following a corporate model. Middle management personnel will probably participate more in decisions on implementation of policies.

An important theme is the need for the hospital to market its services and to market the concept of health care. These marketing activities will again involve new specialists in the hospital and involve new activities for hospital administrators. Many hospitals may begin to play feeder roles to other elements of the system. These feeder roles will require substantial inter-organizational relationships which will involve new modes of operation and greater challenges to the administrator. Expectations for the administrative role imply that the administrator must be primarily a strategist and an external contact person.

The interviewees whom we have identified as role senders were knowledgeable people, capable in their positions, and concerned about improving the quality of health for all citizens. Some, such as the local planners, were a bit concerned about their own positions with changing legislation, but this did not deter them from responding or using the interview to communicate their concerns.

As role senders, they exerted considerable influence on the changing role of the health care administrator, especially the hospital chief executive officer. As the future evolves some of these role sender groups will disappear to be replaced by others; some will continue in varying degrees of influence. At any rate, the mere presence of these individuals and their agencies quickly dispels the attitude that a hospital is an "island unto itself" with few external forces influencing it. This fact, of course, is recognized by administrators but the key question is their reaction. Will they take a proactive role, and move their institutions toward a position of effective health care or assume a reactive negative attitude? It was difficult to get a "fix" on this attitude from the role senders, but the majority opinion appears to be that administrators are beginning to be proactive, especially the more capable ones. The movement in this positive direction will no doubt be slow, but there is evidence that it is in process. Hopefully, role senders, patients, physicians, consumers, etc. will aid this movement rather than attempt to defeat it. At any rate, much attention to understanding the real nature of the change will be necessary by all parties. Thus, the administrator is cast potentially in the role of change agent. How well he performs will remain to be seen.

Accurate development and utilization of data, and the need for changing delivery systems with integrated relationships between different kinds of institutions within a geographic region, will require changing administrative skills. One cannot escape the general conclusion that the health system is in a state of change which will result in a new and different format than we know now. How soon it will come and the exact nature of the new format will depend upon consumer demands and how well administrators and other health care personnel can meet these demands without unduly increasing regulations to insure compliance.

The interviews with educators and professional association personnel reflected a wide-ranging set of views and a variety of different perspectives on health services administration. Given the non-directive nature of the interviews, it is instructive to note that generally quite different areas of concern emerged from conversation with these individuals than emerged from the earlier administrative or external hospital personnel interviews.

The need to integrate education and work roles, and the need for more contact between educators and administrative personnel in different health care organizations and at different levels are two obvious needs noted by this group. How one balances the preparation for the immediate first entry-level job with the preparation for the long-run career potential of the individual is a critical issue not yet adequately addressed. Undoubtedly, there is a need for more and better thought out continuing education activities. Questions about who is to pay for them, how to conduct them, and who should choose those to attend them need more consideration by all the parties to such health administration decisions.

It is clear that more extensive dialogue, more thought and more analysis, and perhaps more personnel exchange programs between health services administration education programs and the practicing professionals are needed to advance the development of education for the changing role of the health care administrator.

The strongest agreement shown by the respondents to the Delphi was on those issues directly affecting the chief executive officer and his role. There was a high degree of consensus that the chief executive must move away from internal operations, depend more on specialists, and learn to deal with the political process and governmental influence. There was a definite feeling that administrators are experiencing many conflicting demands on their time and do not have the freedom to work on tasks of their choice at times of their selection.

There was considerable disagreement about the type of person who should be running the health care system and how he or she should be trained. The panel did not feel that regional health care systems require a physician administrator, but at the same time, they did feel that all administrative positions require a degree with some health administration emphasis.

Statements concerning the adoption of new ways of thinking and acting by the health care system were disagreed with or only mildly agreed with as representing present reality. These statements concerned more cooperation between hospitals, increased emphasis on alternative delivery systems, a shift toward the public utility model for reimbursement, movement away from dependence on acute care inpatients, and the growth of integrated regional health care. There was strong consensus, however, that these statements represented reality in the next ten years.

There was agreement that the principal concern of the hospital was to provide for patient needs as opposed to the continuation of the status quo of the hospital as an organization. This finding was confirmed in our national survey. This is also in keeping with the expectation that more attention will be focused on community needs and preventive medicine in the future. The result of this shift will mean a greater external commitment on the part of the hospital and especially the chief executive officer. No doubt the chief executive will need to delegate more internal responsibilities and decisions to his staff. This delegation, together with increased external expectations in terms of cost effectiveness and planning, will give rise to the need for more administrative specialists on the administrative staffs of hospitals and other health delivery institutions.

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CHAPTER VI

EDUCATION FOR CAREERS IN HEALTH SERVICES ADMINISTRATION

SUMMARY OF FINDINGS

The principal findings reported in this chapter include the following:

1. Administrators were reported as needing: an analytical mind, a good self-image, confidence, the ability to organize, tolerance for conflict and ambiguity, the ability to make decisions with uncertain information, and knowledge of personnel, accounting, and medical functions.
2. Experience is important for the student before he enters his administrative studies.
3. Substantial experience is necessary in a variety of hospital functions before an individual advances to a chief executive position.
4. Four components of educational programs are identified in a health management education model--including general societal knowledge, management skills, a specialization area, and specific subsystem knowledge.
5. Skills in human relations and interpersonal relationships, in accounting and finance, in planning, in negotiating, and in communication are especially important for administrative personnel.
6. The most important areas of study identified by Delphi respondents included: financial management, administration of health care institutions, nature of the health care system, administrative decision making, and the economics of health.
7. The structure and organization of residency programs need further analysis.
8. The area of continuing education is perhaps one of the most neglected and uncoordinated aspects of health administration.
9. There is no real consensus about continuing education, other than that it will be more critical in the future.

REVIEW OF THE LITERATURE

As originally conceived, the education of the hospital administrator at the Master's level consisted of one academic year (nine months) in residence study at the university, and a full calendar year as an administrative intern (or resident) in a hospital. The year of academic study emphasized managerial skills such as organization, administration, personnel, and financial control. The course work was common to all students with very little chance for electives.

The administrative residency was viewed as an opportunity to learn as much as possible about actual hospital operations and problems without responsibility for solving the problems. The key to the residency was the hospital administrator who was designated as the student's preceptor. Typically, the resident was required to complete a research thesis during the residency. A 1947 manual on the residency (Gillen and Prall) suggested that almost one half of the year be spent on departmental rotation with as much practical work experience in each department as possible.

By the early sixties, curriculum in the Master's programs had become very hospital-specific. Vargos, in a 1962 hospital administration text, recommended that in addition to general administration and public health, the subjects to be taught should include hospital history, hospital organization, hospital planning, hospital accounting, hospital statistics, hospital legislation and legal medicine, a seminar on hospital administration (capstone course), and medical audits.

A number of forces have been acting over the past several years to bring about changes in the traditional program. The expansion of the health care system and new management techniques have meant that the graduate programs must revise curriculums and train people for more than just hospitals. The result has been pressure to include more and more in the academic phase of the program. The response to this pressure has been to reduce or eliminate the residency training. The typical program now has two academic years with a summer work experience between the two years. In addition, many programs are looking for candidates that already have experience in health-related settings.

It is perhaps too early to ascertain what will be the effect of the elimination of the residency program, but researchers are already attempting to evaluate the impact of this change. The University of Chicago changed from a residency to a summer work experience in 1965. A survey of their graduates (Anderson, 1970) found that graduates of the old program gave the residency an evaluation score of 2.00 (1.00 being excellent and 2.00 being good). It ranked in about the middle of the various courses considered. The graduates of the new program gave the summer work experience an evaluation score of 1.54 which ranked third among 23 possibilities. However, when asked to list the strong points of the program, only three percent of the respondents mentioned the summer work experience.

The University of Minnesota reduced its residency in 1970 by two months and added the time to the academic portion of the curriculum. A survey of those graduating under both programs (Mosher, 1974) showed that students in the reduced residency program were more satisfied with the content of the residency and the length of time. They still felt, however, that it was too long. The most valuable aspect of the residency according to the Minnesota graduates was the opportunity to observe the management techniques of the administrator and his staff.

Stadler (1969) in a survey of Xavier University graduates found that residents felt line authority for a particular department and confrontation with problems in work situations were the most meaningful experiences. Respondents felt the residency was weak in the areas of personnel relationships, preceptor relationships, university guidance, and shortness of the residency.

McCool (1974) in a study of the hospital administration residency asked whether or not clinical experience needed to be a part of graduate hospital administration education. She questioned whether or not the medical model of theory and clinical practice was appropriate for someone destined to be an institutional manager. McCool suggested that the business model where the student develops skills after graduation as a management trainee may be more suitable.

In many instances, the business model is being followed by individual students. It is not unusual for a graduate of a two-year academic program to seek out what would normally be a residency, but is in effect a one-year management trainee position.

The academic portion of the health management programs has changed considerably over the years. Arnold (1971) traced the evolution of the curriculum in the following manner:

1. Originally emphasis was on functions of the administrator such as planning, organizing, coordinating, and controlling.
2. In the middle 50's, the emphasis shifted to motivational concerns (Human relations era).
3. The management science era started in the late 60's with an increased emphasis on quantitative data for administrative decision making. Included in this emphasis were mathematical model building, systems analysis, and economic models.

Saren (1971) reviewed the curriculum of 11 health management programs and concluded they were moving toward an interdisciplinary orientation. He found programs using other relevant fields such as sociology, psychology, operations research, administrative theory, and economics.

Jaeger (1972) in proposing a model curricula for undergraduate, graduate, and doctoral training, felt two major trends in health administration called for the incorporation of more behavioral and quantitative methods into the programs. These trends are the increased horizontal and vertical integration in the health field, and the increasing specialization of effort taking place just below the top executive level.

Programs in health services management do not, of course, operate in a vacuum. There is a great deal of cross-fertilization, primarily through the Association of University Programs in Health Administration (AUPHA). In response to the need for constant reassessment of the currency of curriculum, AUPHA has developed a number of ongoing task force groups on various aspects of health administration. These task forces are composed of both educators and practitioners. Some of the topics covered are mental health administration, quantitative methods, financial management, organization and administration, and long-term care. Task force reports are routinely made available to all member institutions.

In addition to the task forces, AUPHA recently completed a major project designed to explore the present and future contribution of specific health and behavioral science disciplines to health administration education. The principal product of the project will be a collection of 17 major commissioned papers in as many disciplines.

Another source of curriculum review in the field is the Accrediting Commission on Graduate Education for Health Administration. The commission constantly evaluates and revises its standards for accreditation. The latest criteria in the curriculum area stated:

> IV. The Curriculum
>
> B. The curriculum shall be designed primarily to prepare the student for a career in health services administration.
>
> Comment. Each graduate program may give varying emphasis to specific areas or particular course content. In general, the following areas will be included.
>
> 1. The study of relevant aspects of social-behavioral and management sciences.
> 2. The study of individual, social and environmental determinants of health and disease.
> 3. The study of the elements of medical care.
> 4. The application of administrative concepts and skills in specific health services organizations and programs. (Accrediting Commission on Graduate Education for Hospital Administration, 1976: pp. 3-4.)

Periodically, the state of the art in health administration has been reviewed by privately funded commissions. The latest of these efforts, the Commission on Education for Health Administration, was funded by the W. K. Kellogg Foundation and made a number of recommendations for program improvements. In their summary report (1974), they recommend that curricula should have:

> -as great a breadth and depth of content as available resources allow, pertaining to the two core areas of: (1) health, and (2) administration. The first area should include information on health and disease, health and medical care organization, and environmental management; the second area, administrative theory and skills and applied behavioral science content, particularly that relating to social organizations and political processes.
>
> -use of specialist training, in such fields as financial and personnel management, and systems engineering, available in other schools or departments. Education of the generalist administrator should focus on how to use specialists effectively and should be concerned with methods for selecting, managing, and motivating staff specialists. (p. 8)

This last point, the relative amount of generalized education verus specialized content, has been a basic educational issue in programs in health administration for some time. In one of the first reports of the AUPHA project, Russell and Redmond (1977) commented on the unique aspects of health service administration which create a need for specialization. Aspects noted included:

1. The health care industry is a "people-oriented" industry.
2. The health care industry is highly structured and dominated by a variety of highly educated and trained professionals.
3. The goals of health care institutions are different from industrial and business institutions.
4. The health care administrator must provide a service considered to be a right instead of a privilege.
5. The administrator must assume an unusual obligation for the protection of patient interests.
6. Health care administration lacks the same incentives present in some other industries.
7. The health services administrator has to be oriented to a variety of external issues.

8. The health services industry is becoming a highly regulated industry. (pp. 3-4)

Russell and Redmond argued that these unique aspects of health administration require more emphasis on planning skills, financial management, and communication skills.

Schuler (1972) developed a similar list of unique characteristics for health administration and further observed that hospitals exhibit some monopolistic traits making normal marketplace price setting ineffective. He further thought that health administrators must face the moral and ethical issues of health service.

Brown (1973) in an article on training for health services management agreed that there were unique aspects, but he also felt:

> The functions of an executive are the same whatever the field in which he functions and it is the field that represents the difference. (p. 17)
>
> The field differences are the justification for a special program in health services management and for this reason a variety of special programs is not indicated. If an executive position requires formal training in the field differences, such training cannot be effectively sub-specialized. The field is different as a whole and not by its parts. (pp. 18-19)

Brown argued that manpower needs in health services management can be categorized into executives, functionaries, policy makers, planners, and researchers. He felt that programs for training of health services executives should be supplementary rather than primary in the training of the other categories.

Another basic issue programs are struggling with at the moment is the place of undergraduate education for health administration. Recently there has been a proliferation of programs at the associate and baccalaureate levels. The objective of some of these programs is to train administrators for positions in small hospitals or nursing homes, while others are aimed at middle management. Many programs, however, have the same objectives as the graduate programs. Raffel (1969), in describing the undergraduate program at Penn State University, asserted that their curriculum was designed for top management skills. He went on to say:

> Students today are better prepared, more sophisticated, and more mature than they were a decade or two ago. ...College material is now being taught in high school, and graduate school material is being taught to undergraduates. (pp. 867-868)

Wren (1973) felt that undergraduate programs should be for education of technical and semi-professional administrative assistants. Such programs would educate these students for administrative positions which would be supportive of professional hospital administrators who have obtained a Master's degree.

Brown (1973) was of the opinion that baccalaureate programs in health administration may be a disservice to the student. While recognizing that there are institutions and agencies that might not be able to afford a person with a Master's degree, Brown was concerned that the undergraduate degree in health administration will "short-cut the individual's general education without providing any very meaningful exposure to either the basic courses in management or those in the health field (p. 20)." He proposed that continuing education programs be developed to meet the management training needs of smaller institutions.

The area of continuing education is perhaps one of the most neglected and uncoordinated aspects of health administration. A host of independent and professional organizations are offering learning experiences under the rubric of "life-long learning." The problem is that much of what is offered is either duplicative or represents a piece-meal approach. Programs which are well designed, purposeful, and lead the student to a pre-planned objective are few and far between. Schechter (1974) felt that the key issue was lack of coordination.

> Professional organizations, government agencies, trade associations, universities and colleges, and a variety of entrepreneurs have moved ahead, frequently oblivious of, or uninterested in, the work of others. Health care institutions pay large dues to support overlapping organizations that find it difficult to give up the prerogatives of autonomy and frequently duplicate one another's programs simply because they are strong enough to put together faculty and finance. ...Effective coordination is difficult but not impossible to achieve; not to achieve it will be intolerable. (p. 95)

The recent Kellogg Commission on Education for Health Administration (1974) strongly recommended that programs develop life-long learning opportunities for all levels of health administration. Specifically, they felt there should be:

> -development of nonresident external degree programs in health administration;
>
> -coordination of continuing education and inservice training activities including the development of a registry and information exchange about course offerings;
>
> -coordination of educational program record keeping and development of methods for reciprocal credit granting;
>
> -development of a national program of certification based on competency testing and experience validation; and
>
> -development and testing of the concept of a community-based "open school" of health administration, as described in the text of this report, on a demonstration or pilot project basis. (p. 7)

The type of education which the health services administrator should have is open to much debate. The role and activities of the health services administrator are presently in a state of change. Thus it is difficult, if not impossible, to delineate the type of education which every health services administrator should have. What an education in health services administration prepares a student to do is also unclear. Should it prepare the student for the first job? Should it prepare the student to be a chief executive officer in some sort of health institution, or should it prepare him to deal with the variety of outside forces impinging on the health institution? Or, should it do all of these things? Obviously, a limited amount of education cannot prepare the student for every potential eventuality. Thus, continuing training and continuing formal education become further topics of consideration in discussing education for health services administration.

There seems little question that the role of the health services administrator is changing. In particular, if we narrow the term health services administrator so that we focus only on hospital administrators, the types of changes occurring are even more evident. Chapter V detailed some of the future expectations of hospital administrative personnel regarding the substantial changes which they anticipate in the years ahead. It seems clear that the nature of health delivery systems of the future will be different from what they are now. It also seems clear that there will be more governmental involvement in health care. More external relationships will involve the health care administrator, and the administrator will more likely become the external representative of the hospital in his community.

The role of the health services administrator is also changing in terms of orientation of the individual toward general management skills or toward specialized skills and training in a particular area in the health care institution. What is becoming increasingly clear is that the health services administrator by himself can no longer be all things to all people. Thus, substantial questions occur regarding the education of health services administrators to fulfill the various changing roles which will confront them in the future.

This section summarizes a large number of statements and insights regarding the education of health services administrators made in interviews by individuals in administrative positions in hospitals as well as by other individuals fulfilling health care administration roles outside hospitals. These latter individuals include those in planning agencies, HMO's, PSRO's, and third party payment organizations. This report attempts in essence to delineate the areas of concern in terms of the broad patterns mentioned by the different interviewees.

HEALTH SERVICES ADMINISTRATION EDUCATION: THE HOSPITAL ADMINISTRATIVE PERSPECTIVE

Hospitals are currently the major consumers of individuals educated in graduate health services administration programs. Many current hospital administrators are graduates of health services administration programs and hold a Master's degree in health administration. Both from the perspective of being a major consumer of graduates and of being graduates themselves, hospital administrative personnel might be expected to have substantial insight into the education needed for future health services administration students.

Student Qualities

The prospective student needs to recognize the tremendous challenges and be aware of the great diversity of interests and abilities which the future hospital administrator must have. It is especially important for the student to be able to have his own values in order as he enters health services administration programs. Maturity, good judgment, and leadership skills are important qualities as are logic and critical thinking, honesty, inner integrity, a dedication to people, and a recognition of the realities of hospital administration. Administrators have tremendous demands on their time and administrative positions often require an individual to be very "hard-nosed." These various qualities seem potentially important in terms of self-selection of candidates into health services administration programs.

The market for hospital administrators is much more competitive today than was true in the past. In selecting students for health services administration programs, intelligence, adaptability, and a balance between ego drive and empathy are critical areas of concern since a good student is potentially able to become a good administrator regardless of the curriculum that is studied. Selection of students for programs is a critical issue, and more time should be spent on the initial selection process for students. Field experience is important for the student before he enters his administrative studies.

The Future Administrator's Degree

Specific study of health services administration and a Master's degree in health administration seemed critical for success to some interviewees, and not at all important to other interviewees. The MHA degree may be similar to a union card, and, as that sort of credential, may be valuable in aiding the student to get his foot in the door; however, any Master's degree in management may be just as useful as a Master's in hospital administration. A few suggested that the MBA may even provide more technical skills, while the MHA may be too vocationally oriented, and focus too much--at least in some programs--on how activities are carried out in the hospitals of the programs' favorite guest speakers. Basic health courses may be important for the Master's level program, but probably more important are such courses as quantitative methods and management analysis so that the administration student can better understand the health institution as a complex organization.

The best preparation for health services administration careers is unclear. Another issue is the undergraduate preparation of the health services administrator. A strong undergraduate major in business and some "real world" in-hospital experience before pursuing an advanced degree seem very useful. Background and experience potentially indicate the individual's own management future.

Graduates of hospital administration programs may not be what are needed in the hospitals. The educational program for administrators must be broadened because the role of the administrator himself has broadened. Some noted that it was possible to be a successful hospital administrator without a Master's degree, but that, due to changes in the field, this was becoming much more difficult. Others felt that it was important for the student to have a specialty as well as general administrative training, so that he would have legitimacy in his early employment experiences. It is clear that graduates of any program are not immediately going to be administrators of entire institutions, as once might have been the case. Students will have to be mobile, and will have to be willing to adapt to changing circumstances. It is simply impossible for an educational program to cover all the skills needed by the administrator at the present time. Thus, the administrator must be able to continue his learning after he receives a degree.

The Master's program in administration must strike a balance between quantitative courses, such as operations research, and behavioral science courses stressing interpersonal relations. It also is important for the Master's program to look at alternative programs in health care delivery to better understand other potential means for serving community needs. Some interviewees commented that administration students receive too much education on the social aspects of the administrative role, such as human relations, but do not have enough skills in the basic areas of decision making, planning, and communications. It may be possible for some students to specialize in different aspects of the administrative role--for example, in internal hospital relationships or in external community relationships. The need for in-depth study and in-depth analysis is critical. This depth might be achieved through residency programs, theses, or other comprehensive projects which offer the student the chance to delve deeply into one area. The traditional management areas of planning, organizing, and controlling still represented major areas of need for the Master's in hospital administration student.

How does the prospective administrator get the skills which current administrative personnel feel he needs? To some extent, the prospective administrator may be thought of as the ideal type of Renaissance Man. Taking a collective picture across the various interviews, administrators should have an analytical mind, good self-image, confidence, the ability to organize, tolerance for conflict and ambiguity, the ability to make decisions with uncertain information, and must, in addition to the traditional areas of personnel, accounting, and medical functions, have extensive knowledge of changing social and economic situations. Conflicting elements and factions in health care and problems in the distribution of scarce resources often lead to unstructured decision making. Thus, the ideal administrator must be able to analyze trends and know the corresponding direction the hospital must take. He must have the ability to perceive and interpret what is happening around him, and at the same time, must have a knowledge of strategy so that he can carefully, quickly, and clearly identify the options which are available--both for his institution and for himself in the myriad of situations which face him.

Educational Coursework

On a more pragmatic level, what should be included in the education of the health care services prospective administrator? Most frequently emphasized, and perhaps most difficult to teach, was the need for better skills in human relations and interpersonal relationships. Included in this category would be skill in conflict resolution, in dealing with and controlling divergent groups within the hospital, in understanding younger workers who may not be motivated by money, and, in general, in understanding the psychology of motivation in all sorts of people. Related to this skill is the need of the administrator himself to be aware of and to handle a great deal of tension and to withstand a great deal of pressure. These skills may best be summed up by saying that the chief executive officer should have the ability to relate well to other people. How one instills this skill in prospective administrators is a critical challenge. On the other hand, perhaps this skill in relating well to other people is what will distinguish the health administration leader of the future from his second and third level specialists.

The second most frequently mentioned skill area includes the general area of accounting and finance. Financial expertise is critical for the success of an administrator. He must know his financial data sufficiently so that he can understand the specialists who may advise him in the financial area. Third party reimbursement systems and financial control systems are major areas of concern related to this general heading of financial skills.

A third critical area of concern relates to the need for skills in planning. Planning has become, and probably will remain, critically important for the health institution. The general influence of regulatory agencies upon the administrator, and the impact of regulations, must be well understood by the prospective administration student. Related to this area of planning and governmental regulation is a clear understanding of what we might term "political skills." The ability to work with political forces--really, to work with a community--will determine administrative success in the future. Understanding of the appropriate kinds of behavior, of appropriate points of influence, and of appropriate concepts for presentation to or from different audiences will all be important for the administrator.

Other skills appropriate for the future administrator include skills in negotiating. It seems clear that administrators in the future will no longer be in the position of telling people what to do, but will much more be negotiating with and working with people to persuade and convince them that certain courses of action are appropriate. Thus skills in negotiation will be critical. Related to this, of course, is a better understanding of the future role of labor unions as another external force influencing hospital policies.

Administrators in the future will more often play the role of educator. For this, they will need more knowledge and more ability in communications and educational skills. Communication again will focus on internal, as well as external aspects of the hospital. The significance of good communication, and the ability to be a good salesman in selling a particular program to others will become paramount. The administrator must develop a sense of accountability and skills in identifying key people, and helping these key people to set objectives for themselves which mesh with the objectives of the institution. Finally, the administrator must not only communicate to others, but must also be a good listener as others communicate with him.

Other needed techniques will include statistical ability, computer knowledge, industrial engineering techniques, and some understanding of purchasing activities. It will be important for the administrator to understand not only what data processing and computers can do, but also what is worth doing with a computer. The role of information systems and the control of information within the institution will be important, and are skills best learned during pre-career education. Finally, administrators must be capable of creative thinking, must be innovative, must be flexible and willing to change with the times, and must have the ability themselves to bring about change in their institutions--again, some characteristics most reminiscent of the Renaissance Man.

The Residency

The interviewees' position on the residency is at best mixed. Some felt quite strongly that the residency or internship was a useful kind of program for developing administrators. Others felt just as strongly that residency programs are inappropriate since residents are wrapped up in unreal or theoretical issues, or become "messenger boys" with no real or direct responsibilities and, in turn, no beneficial learning. That residencies do not allow individuals to use analytical skills was the feeling of some, while others felt just as strongly that a residency was the best kind of program through which to enter a hospital administration career. Other industries do not use residency programs as such, and thus, it seems questionable that a residency is really critical in the health care industry. On the other hand, the residency does give the hospital a chance to look carefully at the student and also gives the student a chance to look carefully at the hospital. Residencies should be flexible and if a person has substantial health care experience before seeking a degree, he should be exempted from the residency; the person without substantial experience would have a residency as part of his Master's program. Clearly, much education of future administrators does occur on early jobs, and thus some structure to these early learning experiences might be useful. For the residency itself, the characteristics of the preceptor and the extent of faculty involvement seem to be important factors in some interviewees' evaluation of the residency. A structured learning environment, clear-cut goals, and clearly delineated activities for the individual trainee were other factors which may be important to consider in evaluating any particular residency.

Certain areas do seem to be best learned by on-the-job training and experience. Certainly, skills in working with and managing people ultimately must be tested in real-life situations. Contacts with medical staff and with boards also can be best learned in a master-tutor kind of relationship. It will take an individual potentially five or ten years to learn how to manage a health care institution in a sophisticated way. The place to begin a health services administration career may be at a major medical center--both for the learning experiences which can occur there, and because it is easy to move from a major medical center to other units in the health system. It seems clear, however, that the larger the institution in which the residency or first job is held, the smaller will be the areas of responsibility actually delegated to the new graduate.

The greatly increased competition for advancement may be a motivating factor. Entry level jobs are often available at the departmental level. These types of jobs would help clarify for the individual how the hospital's different departments related to each other. Staff positions and rotation through a number of projects before assuming line responsibilities are other possibilities. Carrying this a step further, one interviewee suggested that a student considering hospital administration should gain some experience at the lowest possible entry level in a hospital, and in that way better understand the needs and activities of the people he would some day manage. Another interviewee suggested that working near or in the nursing function of the hospital would enable a prospective administrator to gain a better grasp of the total operation of an institution. These positions are perhaps extreme, but they do emphasize the apparent consensus that substantial experience is necessary in a variety of hospital functions before an individual advances to a chief executive position.

Continuing Education for the Hospital Administrator

Continuing education for the person in the field is a theme running throughout the interviews. The ideas that the administrator's education never ends, that his learning must be life-long, and that he must keep up to date on hospital and management breakthroughs were often repeated. How an administrator does this is not nearly as clear nor agreed upon as the fact that it must be done.

Comments about continuing education range from those suggesting that better programs of continuing education are needed through evaluative comments--such as the current system does not offer very good continuing education to a generally expressed desire for continuing education programs. Time seems to be a critical factor for many administrators in their selection of continuing education programs. One-year fellowships or leaves-of-absence do not seem desirable, but the two- to four-day conference also received some criticism, as did instructional forms in which one faculty member lectures to a large group of administrators. Continuing education programs should be suited to the needs of the people who participate in them, but how this is to be done is not at all clear. Some administrators suggested that continuing education was strictly an individual effort and that, because many hospitals are small, costs restrict them from participating in continuing education activities. Again, however, the theme is heard that top management should encourage continuing education, should themselves conduct continuing education programs in their hospitals, and that in fact continuing education should be a requirement for continued participation on the hospital staff.

Participation in ACHA activities and AHA activities was one suggested form of continuing education. In some hospitals, generalists on the staff (associate and assistant administrative personnel) were encouraged to work towards membership in ACHA, to attend national meetings, and to generally be active in these organizations. Attending such seminars may be one important way for the administrator to keep abreast of the hospital field. On the other hand, comments were heard that these same organizations and their sponsored functions were not worthwhile activities for continuing education. Individuals suggested rather that reading journals and related kinds of materials was a better program for continuing education. One institution described a regular reading and discussion program which the institution adopted for its senior management team. Thus, there is much variety in the field of continuing education with many different viewpoints about the value of different forms of activity.

It is likely for individuals specializing in certain areas that association-sponsored institutes will be important sources of continuing education and updating. It also seems likely that some requirement for continuing education of hospital administrators will become a necessity in the future, be this in the form of continuing graduate education, continuing attendance at institutes and seminars, or attendance at annual meetings of different associations. Some hospitals already insist upon such participation as part of their administrators' job requirements.

Skill requirements will continue to change, and certain skill requirements become critically important only when an individual is in a certain position. It is also likely--given the nature of learning processes--that individuals will take to learning certain skills with more dedication, and more learning success, when their job demands clearly demonstrate the necessity for these skills. Skills in dealing with governmental agencies, and skills in human relations training and group dynamics are particular areas appropriate for continuing education programs. These may be the fastest changing, or the most difficult skills to learn in a pre-career type of program. Again, great variety in the format of continuing education programs is needed. One potentially innovative type of program could bring a group of administrators together, and each administrator might be required to present a paper, be a discussion leader, and generally interact with other administrators in small groups to develop position papers on the issues facing their hospitals and health care delivery. This self-taught type of seminar approach could be very useful but it seems important that it not focus upon the daily "run-of-the-mill" activities, but rather maintain a focus beyond the daily operating tasks. Of course, lower level administrators or middle-management department head type administrators might very well need to focus on specific operating problems in their continuing education activities. There is no real consensus about continuing education as it was discussed by the interviewees, other than a consensus that it will become more critical in maintaining a viable administrative role in the future.

HEALTH SERVICES ADMINISTRATION EDUCATION:
THE PERSPECTIVE OF THOSE OUTSIDE THE HOSPITAL

Individuals in planning positions, HMO administrators, third-party payment personnel, and officials with PSRO's were interviewed. The goal of these interviews was to capture other sides of the administrative person than might be seen by the individual within the hospital setting itself. However, many of the same themes do emerge in these interviews with an occasional shift in emphasis, but with the same basic concept at the core.

The health professionals external to the hospital indicated that students should definitely be given a broader systems orientation than they are now given. The administrator needs to be knowledgeable about the entire health system and about the interrelationships which exist between different health care delivery units. Hospital administrators of the future will need more skills in conceptualizing the hospital role in the community. Especially important for administrators will be understanding strategy, and identifying the options available to the institution. Ambulatory care organizations' administrators generally noted that hospital administrators were not presently trained to handle out-patients or other non-traditional activities.

Administrators should be research consumers who understand the health care system and are able to use the facilities of the entire system for decision making. Administrators need to better understand themselves, and their role as well as the professional concepts that various individuals in the hospital operate under. The hospital administrator must be able to understand clearly the different disciplines he has to coordinate in terms of both their daily management and longer range fiscal planning. It is essential to be able to converse intelligently with specialists and to be able to understand what is occurring in the specialists' areas. Thus, the administrator will need more depth in his own personal training. Management skills and business oriented skills will be especially critical in the management of new forms of health care delivery systems. Participatory management, a philosophy of self-control and self-regulation, and conflict resolution capabilities will be important parts of the skills of the administrator. He must understand delegation and supervision carefully and clearly.

The ideal administrator of the future will be primarily a planner and a resource allocator. He must not be afraid to innovate--and in fact should not only understand change, but should actively seek to bring it about as an agent of social change. The management of scarce resources and the external emphasis were also mentioned as critical areas by these external professional interviewees. The ability to analyze and prepare written materials, and in general, to deal with written communications suggests a re-emphasis on communication skills, writing skills, and logical analysis skills.

Educational Background

The generalist approach for training chief executive officers is probably appropriate given the broad range of skill areas needed in terms of the educational background of the chief executive. Individuals with specialized educations would be appropriate at second and third levels of administration in the hospital, however.

Especially important is the need for the chief executive officer to recognize a community's needs and the potentiality of putting programs into effect to meet these needs. The chief executive officers must relate to their communities and be community contact men in the future. It will be necessary to deal with diverse groups of people. Thus, the chief executive will need expertise in public relations, in public education, in public contact skills, and the ability to deal with the public in a comfortable and confident manner. Skills in community development received extensive mention among these interviewees.

Hospital administrators must be able to handle data in the future which will entail skills in quantitative analysis and statistics. More importantly, however, they will have to understand data, and related statistical and research terminology. A research methods course may very well be appropriate in their education--especially in terms of understanding the limitations of research. Administrators must be analytic, have the ability to ask for the right information, and must understand what resources are available for decision making so that they can properly gather, use, and analyze data for decision making and forecasting. Knowledge and understanding of public administration and the political process will be important, especially in larger communities. Relating data to the political decision-making process suggests that training in political science will become more important as administrators deal more with federal, state, and local governmental agencies. Political skills may be influential in the planning process, but administrators will need to understand that planning can be a positive factor for meeting community health needs. A different attitude towards planning must be instituted among administration students.

Administrators will need to play a bigger role in area wide planning. They will need to work with planners in a trusting relationship, and thus will need a solid foundation in the planning process. It is not at all clear, however, what skills or attributes are essential for this better understanding of the planning process.

Understanding the legal aspects of administration is another area of importance with an emphasis not on legal training as such, but rather on interpretation, on understanding, and on keeping current with changes in legal aspects related to administration.

Personnel administration and human relations skills are necessary since hospitals are and will be labor intensive, and administrators will continue to deal with people. It will be necessary for administrators to gather and to utilize information on individual abilities, especially in terms of small group behavior and achieving things through committee and peer group activity.

Training in issues related to finance and economics such as better money management and a better ability to justify costs to the public will be necessary in the future. The reliance on a hospital controller may increase because of the specialization required in understanding financial activities, yet the administrator must be the communicator of the financial status of the hospital to the public.

Training in marketing also seems to be appropriate, especially in marketing to meet community needs, not simply to manage the hospital as an organization existing for its own sake. The importance of the community-hospital relationship was frequently emphasized in the discussion with the external professionals. Training in health care and health aspects of administration such as education in health care language may be appropriate but medical knowledge could be gained once on the job. It does seem useful to give the student some basic foundation in medical understanding so that he will be able to communicate adequately with the board, the medical staff, and the hospital staff. The extent of this medical education of necessity must be limited.

There will be more specialization in administrative functions in the hospital. Thus, the administrator must learn selection procedures to develop a staff which is effective, and which complements his own skill. The administrator must continue his own education if he is going to stay "on top" of developments in the field. Finally, administrators themselves need to be secure individuals, to develop intellectual honesty, to understand the obstacles they will face, and above all else, to have common sense.

There were a few comments dealing with the relationship of the chief executive officer and the board. Some felt chief executives may not communicate well enough with their boards, while another interviewee commented that understanding the trusteeship and the trusteeship function are critically needed subjects of study in curricula today, but that they are rarely taught.

COURSES IDENTIFIED BY DELPHI RESPONDENTS

As a follow-up to the interview phase, a Delphi instrument was developed (see Chapter 5). Table VI-1 reproduces the question asked of the respondents relative to the course titles they believed the future administrator should pursue in his or her graduate education. Note that the respondents were asked to make three judgments:

a. Delete by lining out those course titles which you believe are not necessary for the future hospital administrator (or which you feel any educated person should be exposed to).

b. Select and circle the seven course titles which you feel are most important to the future hospital administrator.

c. Rank the seven courses you believe to be most important using 1 as most important, 2 as next in importance, and so on.

The responses to the Delphi question are tabulated in Table VI-2. The number of respondents lining out courses are listed in the column headed "number lining course out." The first nine courses lined out in rank order by number of times mentioned were: 1) calculus (49); 2) political science (30); 3) public speaking (29); 4) general economics (27); 5) the legal system (22); 6) industrial engineering (21); 7) communications (20); 8) data processing (20); and 9) public administration (20). Four other courses were tied for the tenth position. These were: complex organization structure, marketing, hospital public relations, and financial accounting. Unfortunately, the question was asked in such a manner that it was impossible to ascertain whether or not the course was "lined out" because it was not necessary or because any educated person should complete it. The reason for this question wording was to cause the respondent to reduce the number of courses so that the process was more manageable.

Respondents were asked to identify the courses they believed to be most important and then rank the courses on a scale of 1 to 7. A weighted score was developed for each course by assigning seven points to a first rank, six to a second rank, five to a third rank, four to a fourth rank, three to a fifth rank,

TABLE VI-1

DELPHI: EDUCATION SECTION

In our interviews, numerous skills, abilities, and courses were noted as important for the career success of the hospital administration candidate. The course titles identified by all of the interviewees are listed below.

We would like you to:

a) delete by lining out those course titles which you believe are not necessary for the future hospital administrator (or which you feel any educated person should be exposed to);

b) select and circle the seven course titles which you feel are most important to the future hospital administrator;

c) rank the seven courses you believe to be most important using 1 as most important, 2 as next in importance, and so on.

Financial Accounting
Financial Management
Budgeting
Data Processing
Operations Analysis
Systems Analysis
Industrial Engineering
Calculus
Statistics
Managerial Economics
General Economics
Economics of Health
Health Planning

Collective Bargaining
Personnel Management
Administrative Decision-Making
Group Behavior
Program Planning
Program Evaluation

Administration of Health Care Institution
Complex Organization Structure
Politics of Health
Medical Sociology
The Nature of the Health Care System
Medical Staff Relations
Marketing
The Legal System
Health Care Law
Residency or Internship

Public Speaking
Communications
Hospital Public Relations
Community Political Processes
Political Science
Public Administration
Conflict Resolution
Other (please specify) ____________________

____

____

two to a sixth rank, and one to a seventh rank. Using this weighting process, ten courses were identified and are listed in Table VI-3. Courses receiving over 100 weighted points were financial management, administration of health care institutions, the nature of the health care system, and administrative decision making. Other courses identified as important were: medical staff relationships, economics of health, health care law, the residency, politics of health and complex organization structure. It is important to note that these courses generally were cast in the health care structure or format. For example, administration, economics, and politics can and are taught as general courses. These respondents indicated such courses should be related specifically to the health care system.

ANALYSIS OF QUESTIONNAIRE

EDUCATIONAL INFORMATION

As a part of the questionnaire phase of the project, those receiving questionnaires were asked to send a copy of their job descriptions. A usual part of a job description is the personal qualifications section or job specifications. Not all of the job descriptions had this section; many simply stated that the chief executive officer must be competent without expanding upon the concept. A number, however, did include a personal qualifications section. These descriptions were analyzed utilizing the content analysis procedure.

The most important qualifications identified were the ability to get along with people and communications skill. Initiative, leadership, and effective decision making were included as important qualifications. Other characteristics mentioned more than once were ability to accept responsibility, problem identification and solution, acceptance of non-routine hours, the ability to make effective changes, and the ability to set priorities.

TABLE VI-2

EVALUATION OF COURSES[1]

Course Title	Tabulation of Rankings 1	2	3	4	5	6	7	N	Number Lining Course Out[1]	Weighted Score[2]
Financial Accounting	1	0	1	0	0	1	0	3	15	14
Financial Management	9	12	7	7	5	8	3	51	1	232
Budgeting	0	1	3	3	0	0	3	10	8	36
Data Processing	0	0	0	0	0	1	1	2	20	3
Operations Analysis	0	1	2	2	2	0	2	9	6	32
Systems Analysis	1	1	0	4	1	1	1	9	9	35
Industrial Engineering	0	0	0	1	2	0	1	4	21	11
Calculus	0	0	0	0	0	0	0	0	49	0
Statistics	0	0	0	2	1	1	0	4	13	13
Managerial Economics	2	1	1	1	3	1	2	11	10	42
General Economics	0	0	0	0	0	0	1	1	27	1
Economics of Health	3	1	5	4	4	3	1	21	1	87
Health Planning	0	0	3	2	6	2	8	21	1	53
Collective Bargaining	0	0	0	2	0	1	1	4	11	11
Personnel Management	1	0	1	0	3	8	0	13	7	37
Administrative Decision-Making	3	6	3	4	6	4	3	29	4	117
Group Behavior	2	1	1	1	2	0	2	9	13	37
Program Planning	0	2	1	1	3	1	1	9	9	33
Program Evaluation	0	0	1	1	0	2	0	4	9	13
Administration of Health Care Institution	15	16	1	2	1	1	0	36	2	219
Complex Organization Structure	3	1	4	1	0	3	1	13	15	58
Politics of Health	2	3	2	3	2	2	0	14	6	64
Medical Sociology	0	1	1	0	0	1	0	3	13	13
The Nature of the Health Care System	10	2	4	4	1	2	0	23	6	125

TABLE VI-2, CONTINUED

Course Title	Tabulation of Rankings 1	2	3	4	5	6	7	N	Number Lining Course Out[1]	Weighted Score[2]
Medical Staff Relations	2	4	3	4	3	4	5	25	2	91
Marketing	0	0	1	2	0	1	1	5	15	16
The Legal System	0	0	0	1	0	0	0	1	22	4
Health Care Law	0	1	4	4	4	4	10	27	3	72
Residency or Internship	3	3	3	1	3	0	2	15	4	69
Public Speaking	0	0	0	0	0	0	4	4	29	4
Communications	1	2	1	2	3	1	3	13	20	46
Hospital Public Relations	1	0	1	0	0	2	1	5	15	17
Community Political Processes	0	2	5	0	3	3	4	17	10	56
Political Science	0	0	0	0	0	0	0	0	30	0
Public Administration	1	0	0	0	1	0	0	2	20	10
Conflict Resolution	1	0	1	3	2	1	1	9	14	33

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[1] Number lining course out is total number of those lining course out in response to the statement, "Delete by lining out those course titles which you believe are not necessary for the future hospital amdinistrator (or which you feel any educated person should be exposed to).

[2] Weighted score assigns seven points to a first rank, six to a second rank, five to a third rank, four to a fourth rank, three to a fifth rank, two to a sixth rank, and one to a seventh rank.

TABLE VI-3

MOST IMPORTANT COURSES IDENTIFIED BY DELPHI RESPONDENTS

	COURSE	WEIGHTED SCORE
1.	Financial Management	232
2.	Administration of Health Care Institutions	219
3.	Nature of the Health Care System	125
4.	Administrative Decision Making	117
5.	Medical Staff Relationships	91
6.	Economics of Health	87
7.	Health Care Law	72
8.	Residency	69
9.	Politics of Health	64
10.	Complex Organization Structure	58

Respondents to the questionnaire were asked to respond to an open-ended question. The question was: "Based upon your experiences, which skills and abilities should be developed by those in training to become hospital administrators? (We would also like your insights and your thoughts regarding skills and abilities needed in the future by hospital administrators.)" The skills and abilities identified by the respondents are presented in Table VI-4.

The most important skill identified as being needed by a hospital administrator was that of human relations--43 percent of the respondents said this was important. Financial management was considered to be almost as important as 38 percent identified this skill as important. Twenty-six percent of the respondents identified management and organization skills as needed by administrators. In the 17 percent to 18 percent range, the following skills were believed to be significant: political acumen, communications, tolerance-patience, and planning. A fourth group of skills were considered to be of about equal importance. These were medical staff relations, problem solving, public relations, labor relations, and knowledge of medical care. Five other skills and abilities were identified but were of lesser significance in the minds of the respondents than those identified above. Included in this group were abilities acquired in a residency, legal aspects of health, some specialty education, leadership, systems engineering, and marketing and salesmanship.

Questionnaire recipients were also asked to indicate their participation in professional development, education, or training programs during 1975. The results of this query are summarized in Table VI-5 in terms of categories of respondents (hospital, long-term care, clinic or HMO) and program sponsors.

The most important program sponsor for all categories or classes of administrators except HMO administrators was the state or professional association.

TABLE VI-4

SKILLS AND ABILITIES NEEDED TO BE A HOSPITAL ADMINISTRATOR

SKILL OR ABILITY	PERCENT OF TOTAL
Human Relations	43%*
Financial Management	38%
Management and Organization	26%
Political Acumen	18%
Communications	18%
Tolerance - Patience	17%
Planning	17%
Medical Staff Relations	11%
Problem Solving	11%
Public Relations	11%
Labor Relations	11%
Knowledge of Medical Care	8%
Legal Aspects of Health	6%
Residency	5%
Specialty	3%
Leadership	3%
Systems Engineering	3%
Marketing and Salesmanship	3%

*Percentage figures represent the percent of total respondents. For example, 43% of the respondents to the question said human relations skills were needed to be a hospital administrator.

TABLE VI-5

SPONSORS OF PROFESSIONAL DEVELOPMENT, EDUCATION, OR TRAINING PROGRAMS ATTENDED IN 1975
RESPONSE FREQUENCIES

Program Sponsors	Hospital Administrators	Long-Term Care Administrators	Clinic Administrators	HMO Administrators	Total
	N	N	N	N	N
Hospital Sponsored Educational/Training Program[1]	327	79	8	2	416
State Association	539	120	25	2	686
National Association	---[2]	68	22	5	95
American Hospital Association	301	17	1	1	320
American College of Hospital Administrators	327	---[2]	---[2]	---[2]	327
College/University Extension Service	138	72	4	2	216
College/University Degree Course	66	24	2	---	92
American Management Association	41	9	---	2	52
State Government Sponsored	129	75	---	2	206
Hospital Financial Management Association	138	9	2	---	149
Did not attend any programs.	35	4	1	2	42

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[1] Questionnaires sent to long-term care, clinic, and HMO administrators said "Local organization sponsored education/training program."

[2] Not asked on this question form.

HMO administrators said national association programs were most attended. Hospital administrators ranked the hospital sponsored educational/training programs and American College of Hospital Administrators as second in importance. Long-term care administrators also frequently attended locally sponsored programs, while state government sponsored programs were third most important for them, followed closely by college/university extension service and national association programs. The National Association programs were second in importance for clinic administrators, whereas HMO administrators were divided among six kinds of program sponsors.

Respondents were asked to identify reasons why they felt a need for additional education as an incumbent in their present position. As would be expected, the most important reason for additional education was to meet the demands of the present position. This was followed by the reason "my profession expects it" although the HMO personnel also said their boards expected additional education as being of equal importance. Long-term care administrators identified "needed for licensure" as the second most important reason. These results are shown in Table VI-6.

It was interesting to note that not all education was to directly improve position activities. Among the administrators, the need for culture-broadening education was indicated to be of significance. The need for education for licensure was not considered to be important for clinic and HMO administrators and was not asked of hospital respondents.

Respondents were also asked whether or not it was essential for a continuing education course to earn academic credit. As Table VI-7 shows, the response to this question was generally no. Eighty-four percent of the hospital administrators said no, whereas a no response was received from 75 percent of the long-term care administrators. All HMO administrators said no and about 90 percent of the clinic administrators gave a negative response.

TABLE VI-6

REASONS FOR ADDITIONAL EDUCATION

	Hospital Administrators	Long-Term Care Administrators	Clinic Administrators	HMO Administrators	Total
	N	N	N	N	N
My profession expects it.	483	104	19	4	610
Board expects it.	271	52	12	4	339
Need it to meet demands of present position.	638	122	28	5	793
Need it for career advancement.	247	48	9	5	309
Would like to study in some related field.	191	46	9	3	249
Would like culture-broadening education.	271	54	9	3	337
Other reasons.	33	1	5	1	40
Needed for licensure.	---[1]	112	2	1	115

[1] Not asked on this question form.

TABLE VI-7

ACADEMIC CREDIT REQUIREMENT FOR CONTINUING EDUCATION COURSES

	Required		Not Required		Total	
	N	%	N	%	N	%
Hospital Administrators	114	15.77	609	84.23	723	100.00
Long-Term Care Administrators	36	25.35	106	74.65	142	100.00
Clinic Administrators	3	9.68	28	90.32	31	100.00
HMO Administrators	0	0.00	9	100.00	9	100.00
All Respondents	153	16.91	752	83.09	905	100.00

This chapter has presented a brief review of the education literature directed toward a review of recommendations for educational programs for health services administrators. Following the historical background, results from various phases of the study were described including the interview, Delphi and questionnaire phases. Where possible, both academic and continuing education components were reviewed. Given this background, the following section presents a model together with a discussion of a suggested approach to initial or academic-degree oriented education. The model represents both the results of the analysis as well as a conclusion to the data gathering phases of the study.

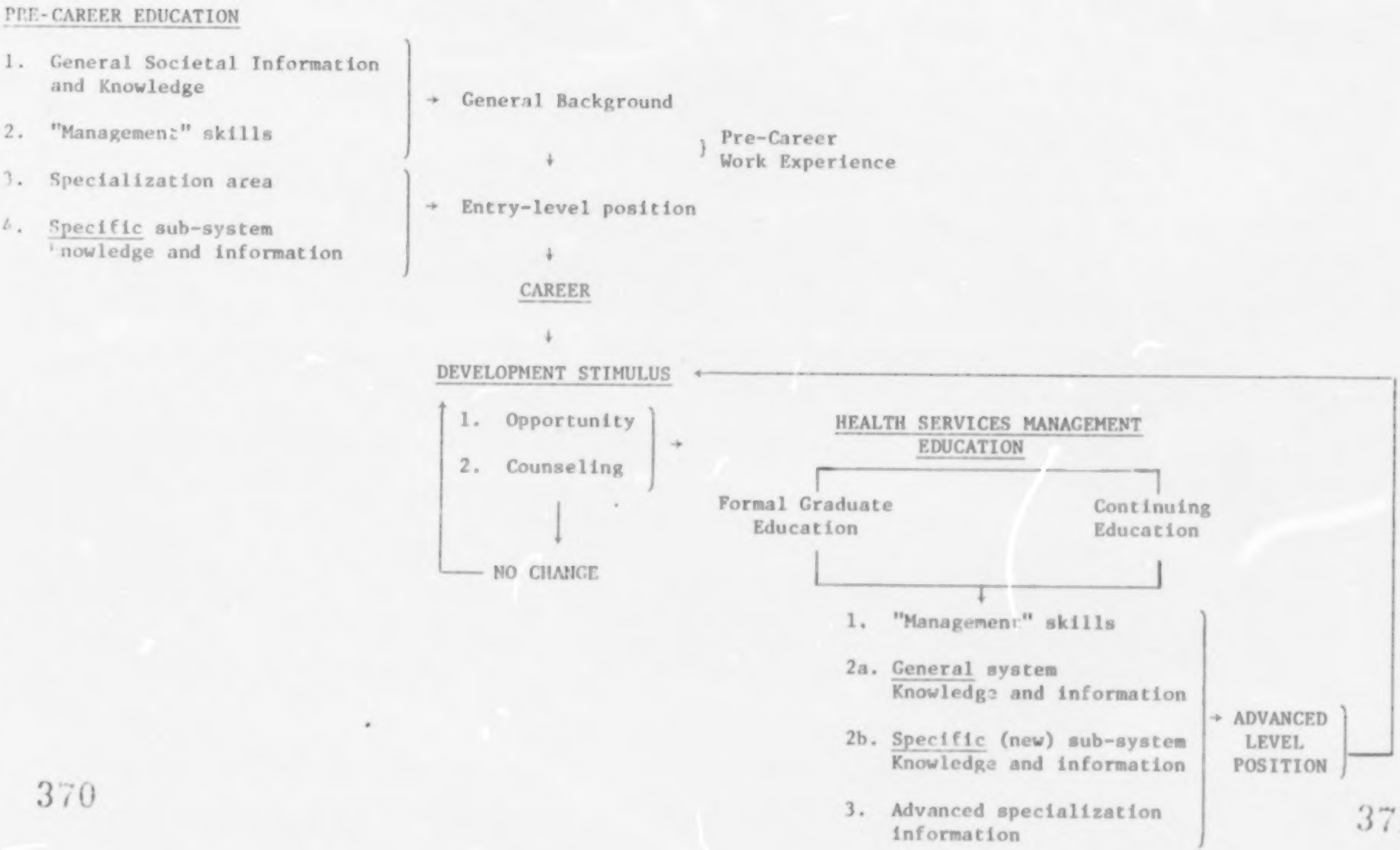
A TENTATIVE MODEL

The tentative model that emerges from these data sources is presented in Figure VI-1. It is a flow model of management education and development because it seems clear that a managerial career flows through certain tracks and cycles and certain stages in an individual's career. The model begins with a pre-career education program which essentially should be composed of four elements. The basic component is a generic development of knowledge and understanding of the general societal environment in which we live. Another component of pre-career education would include certain management skills of a generic non-institutional nature. Such management skills would include basic tools in accounting, finance, statistics, data processing, human relations, and personnel management.

A third element contains a specialization area which is essential to insure the individual's initial employability. Finally, the pre-career component involves the development of certain knowledge and information about the environment and system within which the person will function. This category includes knowledge about the political, social, and governmental aspects of the system environment, such as the health care system, within which the person will work. In some

FIGURE VI-1

A FLOW MODEL OF HEALTH SERVICES MANAGEMENT EDUCATION AND DEVELOPMENT


PRE-CAREER EDUCATION
1. General Societal Information and Knowledge
2. "Management" skills
3. Specialization area
4. Specific sub-system knowledge and information
General Background
Pre-Career Work Experience
Entry-level position
CAREER
DEVELOPMENT STIMULUS
1. Opportunity
2. Counseling
NO CHANGE
HEALTH SERVICES MANAGEMENT EDUCATION
Formal Graduate Education
Continuing Education
1. "Management" skills
2a. General system Knowledge and information
2b. Specific (new) sub-system Knowledge and information
3. Advanced specialization information
ADVANCED LEVEL POSITION

specialties such as the managerial staff specialties, these system courses will be general in nature; in others such as nursing, they will be specific and detailed.

This pre-career concept of the development of the health care system managerial cadre pertains most directly to the undergraduate preparation. Interviewees pointed out generally that an ideal undergraduate preparation is the typical bachelor of business administration degree. The model accommodates this particular degree but is not confined to it. More germane to the discussion is the implicit assumption that these pre-career graduates will usually assume specialist or administrative staff positions in accounting, purchasing, planning, personnel, or data processing.

Other specialties such as nursing can be accommodated by the pre-career section of the model except that little, if any, academic work can be directed toward the management skill development because of the demanding requirements of the specialty of nursing itself. Ordinarily, people in these particular specialties require the development of the general managerial skills as they move into administrative positions such as department heads.

At this point it should be pointed out that most people tend to interrupt their educational career development between their undergraduate and graduate degree programs. Some people do continue their formal education so that their undergraduate and graduate program efforts are combined. In these situations, however, either there was no specialty acquired at the undergraduate level or the person wants to change into a different specialty such as health services administration.

Proceeding through a career, an individual will encounter development stimuli from a variety of sources. Some of these may be opportunities for advancement, involvement in different organizations, or they may be self-directed and self-developed opportunities flowing out of counseling and career planning.

Assuming that the person begins a career in a hospital in an administrative staff position, that person may aspire to the chief executive officer position. It usually is apparent that a Master's in health services administration is a requirement for that position. That person would seek admission to the health services administration program in one of the accredited Master's degree universities. Once admitted, that person would pursue a course of study involving three major components. Those components are:

1. Additional "management" skills
2. General and specific health care system knowledge and analysis
3. Advanced specialty information

A number of courses will be included in the course of study such as those described in Table VI-3 of this chapter. Those courses were financial management, administration of health care institutions, nature of the health care system, administrative decision making, medical staff relations, economics of health, health care law, residency, politics of health, and complex organization structure. Some of these areas such as administration of health care institutions may include a number of courses. For example, options may be developed for hospital, long-term care, mental health, or clinic administrative applications.

Most universities will include some quantitative courses such as statistics, mathematics, data processing, and operations analysis. In addition, a specialization may be stressed either in terms of an administrative skill or an institutional environment such as hospital management.

Two points are of significance. One is the fact that chief executive officers should be more properly called managers rather than administrators. As managers they are becoming increasingly involved in decision making as opposed to administrative implementation of policies and procedures. In addition, they are increasingly involved in decision-making activity with external groups such as planning agencies.

A second point is that graduate education for health care system chief executive officers should be generalist in its format. This is because the CEO must have a broad system perspective. After all, this is a pluralistic society and the health care system and its components are a part of this total system. Thus, the CEO must not have a narrow vocationally oriented approach developed by that type of educational experience. Quite the contrary, he or she must understand the nature of the significant forces in operation in the total system and understand and appreciate how the health care system relates as a component of the total. In addition, it is necessary to ascertain how decisions are made and how a health care system component such as a hospital can develop innovative approaches to meet changes in the nature and expectations of its environment. Of course the CEO must recognize how individuals such as employees, patients, or consultants can be coordinated into an appropriate institutional unit.

In addition to formal graduate education, the individual may be stimulated to participate in some form of continuing education and self-development involving management skills, general systems knowledge and information, possibly specific knowledge of a new subsystem, and advanced specialization information. Management continuing education over time should lead to an advanced level position. The cycle begins again when the individual encounters another development stimulus. Of course, one possible response to a development stimulus is "no change." In this case the individual effectively stagnates until another development stimulus occurs, if in fact, one does occur again.

The sub-elements of pre-career, graduate, and continuing education identified in Figure VI-1 appear to be valid statements of the educational needs of health system administrators. The graduate and continuing education aspects are particularly useful to chief executive officers or for those in training for this level of position. There appears to be consistent concern about understanding the environment/system of operation with special attention to the government as a role sender. There also seems to be concern about specialization in pre-career education and early career stages and more general education at the graduate level.

Of concern are the costs of education. Programs with a large number of specialized courses directed to the health care industry are obviously more expensive than those programs whose courses provide for more general management skills for a variety of industries. Cost-benefit studies regarding educational specialization both from an occupational and institutional point of view are required. However, logic tells us that there are limited funds that can be devoted directly to specialization unless benefits can be clearly identified.

The benefits can be ascertained only in terms of the needs of the system. If administrative specialists in finance, personnel, labor relations, purchasing, etc. are required, then programs need to be developed to meet these kinds of needs. The same rationale can be made for planners and policy makers. Because the chief executive officer is by nature of his position a generalist, then his educational needs are general in nature so that he can cope with the changing pluralistic society. It would appear then that constant examination of the needs of the system must be made and variations in educational programs in turn developed as these needs change. Most important is the necessity to develop solid educational programs directed toward the kinds of specialty needed rather than providing a general "mountain-top" view which unfortunately cannot meet the specialized needs of the health care system.

CONCLUDING COMMENTS

This chapter has summarized recent literature related to the education needs of health services administrators, summarized the findings of this project relative to educational needs, and presented a process-flow model as a curriculum guide for educational programs.

Clearly, we need more research, and more theorizing about management education and development over the career cycle. Too often, management education is viewed as something one goes away for, and with luck, something one brings back to one's organization. Management education is not often enough seen within a broader framework of management and organizational effectiveness. Our model, of course, does not explicitly consider the various issues related to organizational effectiveness. However, based upon the data generated in this research project, it seems clear that practicing managers and executives anticipate that development of management skills and of general systems knowledge and information should improve organizational effectiveness. The Flow Model of Figure VI-1 attempts to place the role of management skills and systems knowledge in perspective as they relate to pre-career, graduate, and continuing education activities.

Financial management, human relations, and other tools received approximately the same emphasis as did the need for analytical and evaluative skills, for planning skills, and for understanding the impact of government and of the environment or system within which organizations operate. The need for first job skills was regularly reported.

Given the great variety of management programs, and the great market for management skills being developed in educational programs at this time, it seems especially appropriate to think about the components of those management/administration educational programs. The Flow Model of management education and development provides one means for assessing different managerial educational programs. Furthermore, it provides a means to reduce some of the developing market segmentation in management-oriented programs. Most of the traditional generic management skills are probably best taught in a business or management school. The general societal information and knowledge require the interaction of political science, sociology, education, and various other departmental areas.

Institutional or specific system knowledge requires the expertise of those in schools of medicine or schools of public health. Finally, given management skills and a broad based system orientation, areas of specialization begin to make more sense--as does specific sub-system knowledge. What may be most necessary in the management education and development field is the application of the same analytical, evaluative, and goal-setting tools which are so often taught to developing managers. Finally and perhaps most important of all, those in pre-career programs must learn to recognize the inevitability of their need for continuing education and accept the reality of life-long learning.

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CHAPTER VII

CHALLENGES FOR THE FUTURE

Anyone with even a cursory understanding of the health delivery system in the United States recognizes that many events have occurred in the recent past and are presently occurring which place the system in a state of change and innovation. Such circumstances of change usually lead to continuing future challenges for the chief actors in such a system. Health administrators and executives in many diverse positions are among those actors for whom the health system changes presently occurring present such challenges.

The purpose of this chapter is to summarize and highlight some of the challenges noted in the conduct of this research. Additional challenges for the field of health services administration are illustrated in the earlier chapters of this report, and thus this chapter is intended to emphasize those issues which are the most significant conclusions of the project--insofar as those conclusions can suggest areas for action and implementation, can note barriers to implementation, and can recommend means to overcome these barriers.

SUMMARY OF MAJOR FUTURE CHALLENGES FOR HEALTH SERVICES ADMINISTRATION

Among the challenges identified in this chapter are the following:

1. The increasing external involvement of chief executive officers.
2. Standards of accountability and clearly defined responsibilities.
3. Coordination and cooperation between different health delivery system units.

4. Horizontal and vertical integration.
5. Task allocation between the chief executive officer and his administrative staff.
6. Utilization of middle management specialists in finance, personnel, risk management, systems engineering, purchasing, etc.
7. The development of a community medicine/preventive medicine orientation.
8. The balance between cost containment and high quality patient care.
9. The composition of health organization boards of trustees.
10. Understanding the needed health industry-specific components of educational programs.
11. Understanding individuals' motivations to engage in continuing education.
12. Continued research and analysis in administrative role delineation.

EXTERNAL CHALLENGES

A major challenge for health services administrators in the future is the increasing external involvement of chief executive officers including, and in some views caused by, the increasing external control and decision-making powers of regulatory agencies of various types. As external system interrelationships demand more time, as external role senders grow in influence, and as representational roles develop, less time and attention are available for internal organizational management activities. This challenge thus involves the manner of adaptation which chief executives choose in order to exercise external and internal roles for their organizations.

It is not clear that there is "one best way" to deal with this issue.

Development of separate Mr. Inside and Mr. Outside roles, involving relatively clear division between chief executive and chief operating officer roles is one strategy noted in the research. Reduction in the number of external representatives needed through merging institutions, developing management and service contracts, or by creation of satellite institutions are all currently employed strategies. Another strategy is the development of administrative specialists in functional areas such as finance, planning, and personnel who can serve as the first line of response to the external requests for information and data. Which of these methods is the best response to the external involvement of the chief executive is perhaps a moot question. It is clear that a critical barrier to successful fulfillment of the role of health services executive is the sheer inability now or in the future for one executive to be all things to all people.

Developing standards of accountability and clearly defined responsibilities for the health organization chief executive and for his delegates who share internal and external management responsibilities is a concern. Along this line, it will be necessary for governing boards in the exercise of their fiduciary responsibility to evaluate the performance and competency of chief executive officers and for chief executive officers to evaluate the performance of their subordinates. The rigor of such evaluations, the capabilities of the evaluators, and the definition of executive performance must receive careful attention in the future.

The external involvement of the chief executive raises a very real question about the desirable levels of coordination and cooperation between different health system units. Stated another way, what are appropriate and workable levels of institutional integration among service delivery units? Concerns about institutional size versus responsiveness versus the desirability of competition and choice are all related to the future role of the chief executive and his fellow administrators. The shape of the health delivery system may well be the most important determinant of the roles of the administrative personnel. Other research has focused on the future shape of the system and, of course, many of the data of this research have also. Various forms of horizontal and vertical integration seem sure to become larger issues in the future.

Evaluation, regulation, and planning are issues also related to the external involvement of the chief executive officer. The appropriate focus of these activities and the roles of agency management within planning bodies, PSRO's and state regulatory agencies are undergoing great change at the present time. A major challenge really is how the direct service agency executives shall relate to these planning, regulation, and evaluation agency executives.

INTERNAL CHALLENGES

Delegation, accountability, and performance evaluation have already been mentioned. Further challenges related to the internal management of institutions involve the allocation of tasks between the chief executive and his subordinates. The development and utilization of middle management administrative-technical specialists in hospitals, in finance, personnel, risk management, systems engineering, purchasing, etc., is an especially important issue involving institutional size and cost. The inability to provide for such specialists in some types of institutions may present a different challenge and stimulus as technical requirements of managerial jobs become more demanding. Many new management programs are planned in the next three years by respondents to the questionnaire. Program budgeting and cost-benefit analyses require advanced levels of staff specialization as do systems engineering programs and many of the other programs listed in Table IV-33. Providing specialists capable of developing and properly using such programs will be especially important.

The challenge of professional and managerial relationships with medical personnel, including the increased need for evaluation of medical decisions, will undoubtedly be a source of tension in the future. Questionnaire respondents reported that patient care related tasks are fairly consistently delegated to others, yet ultimate responsibility for policy and medical activities rests with the Board of Trustees and through it with the chief executive officer. Dealing with increasingly complex medical issues will be a future concern.

The development of a community medicine or preventive medicine orientation is another challenge for administrative personnel, given the fact that doctors are traditionally independent practitioners, rather than organizational employees, although there is some evidence that this is changing. The low level of interest in organizing health maintenance organizations expressed by questionnaire respondents is suggestive of the challenge in the delivery of medical care services through new means which faces the system as a whole.

Developing organizational goals to conform with concepts which appear to be valued by other elements of the health system is another interesting issue. Shared services has been a popular theme in many discussions of health resources. Yet, the questionnaire respondents rated it moderately important as a goal, at best, in Table IV-22.

The balance between cost containment and high quality patient care will be difficult for administrators to achieve as medical technology increases in its capabilities, and as more questions are raised about the cost of applying that technology. How to make decisions which blend cost components, medical judgments, and human compassion in individually, organizationally, and socially acceptable ways must be a concern.

The composition of health organization Boards of Trustees--including the appropriate roles of management staff, medical staff, consumer groups, and employees--presents another problem. Furthermore, it is unclear how representatives of these groups, and especially of consumer groups, can be chosen even if a board desires their representation. Other health agencies have similar problems in terms of Board membership or advisory groups. Clinics represent an especially interesting case, given their profit-making orientation.

Along with membership and representational concerns, Boards of Trustees face other more substantive challenges in delivering, evaluating, and assuring quality, comprehensive health care to their communities. If there are large infusions of public funds into health care, the demands placed upon governing bodies are likely to increase, and in turn the need for board education will grow. Whether that education is to be a duty of the chief executive (who is really the most senior employee of the board) or whether it will be developed by other agencies presents an interesting challenge.

EDUCATIONAL CHALLENGES

The educational challenges arising from the research are perhaps most important in that they have the potential of the most impact over the long term. The need for education for a variety of administrative roles within the health care system and the need for continuing educational programs to update and upgrade individuals to meet the changing requirements of their positions are chief among these.

The need for education for a variety of administrative roles within the health care system is clear from the research. What is not clear is the appropriate form of that education. The challenge for educators is to develop individuals suitable for the wide variety of administrative roles at a cost which can be borne by the health and educational systems. The model presented in Figure VI-1 suggests that much of that administrative education may be similar to that provided individuals entering other sectors of the economy. Management skills, for example, are assumed to be relatively generic and cross-industry in nature. Determining the appropriate, specific health sub-system skills necessary for the prospective health administrator is a major concern.

Determining the institutional differences which require different types of training is a further need. It seems apparent from the research that there are clear differences between clinic and hospital administrators--at least in the direct performance of financial tasks. Where long-term care administrators differ, if at all, is not so clear. The present educational backgrounds of these groups also clearly differ; a key unanswered question is whether that difference in education causes a performance difference.

A further challenge lies in investigating the proposal of Figure VI-1 that management skills are generic in nature. The research data do not indicate any consistent, identifiable differences in questionnaire responses flowing from one educational background versus another. Without further probing of program content and outcomes, it is unclear whether the students produced, for example, by an M.B.A. program really differ in performance capabilities and effectiveness from those produced by an M.H.A. program. Whether there are outcome or performance differences based on different educational tracks is an unanswered question. The model presented in Figure VI-1 suggests, based on the data available, that general societal/cultural knowledge and "management" skills need not be health industry-specific. Yet, the boundaries and shape of the required specific health industry sub-system knowledge and information are not well defined, nor is it clear how this knowledge is best communicated. A challenge for the future lies in further developing those distinctive educational features which especially prepare an individual for an effective health industry management career. A further challenge lies in developing adequate specialization areas to assist early career placements of graduates.

Another educational challenge appears in the development of the administrative specialist. Where will the materials handlers and the health facility construction specialists come from? Clearly not every health administration program can or should turn out health oriented specialists in these areas. But which programs should? What balance is needed between vocational technical preparation and academic preparation for administrative specialists? Furthermore, what are the implications for individuals in terms of their career ladders? It seems likely that the R.N.--L.P.N. model of training has some distinct disadvantages for some individuals; yet, that is precisely the model that a vocational-academic separation leads one to. Given the goals of this research project and its focus on senior administrative personnel, no answers to these issues are available from the data collected. The data do indicate, however, a concern about the sources and backgrounds of administrative specialists which is felt by the senior staff personnel.

Orientation of the new graduate must become a more active concern of health system administrators and educators. Often, the new entrant to business organizations is oriented through a formal training program. This formal trainee orientation appears to be less clear in health fields. Residencies and internships abound, but their structure and format vary considerably. The issue may also be raised that the one trainee--training program/residency is inefficient. It may require more time and may produce less benefit for the individual than would occur through a larger program conducted at major medical centers where there could be a training leader or full-time residency supervisor. The hospital with one medical resident would most likely not receive much approbation from the medical profession; yet, the hospital with one administrative resident is the norm! Again, the data raise this issue, but, given the purpose of this research, do not answer these questions. Structured residencies and more formalized job entry orientations are areas for further analysis.

A second major area of educational challenge involves continuing education programs to update and upgrade individuals to meet the changing requirements of their positions and to enable them to fulfill newly emerging roles. How to get individuals into the right programs, how to structure such programs, and how to pay for them are all elements of the continuing education challenge. A key factor involves individual differences and the recognition and acceptance of the fact that there cannot be one program format which will ideally or even adequately meet the needs of all administrative personnel.

A better understanding of the motivation of individuals to engage in continuing education is needed. Such motivation may well need to be developed and such development in fact may become an increasingly important part of the chief executive's role. It seems clear from the interview data that hospital leaders do accept such motivational responsibilities as part of their proper activities. How far down in the organizational structure does such responsibility carry, what is the appropriate balance between technical and generalist components of continuing education, who is to pay for it--the individual or the organization--and so forth are issues needing further study.

Another issue involves the role of counseling in determining career movements and opportunities. Who is best able to advise individuals on their continuing education needs or on the developmental consequences of particular choices about employment which they may make? Of course, this issue is not solely limited to health services administrators, but is a general problem for the economy as a whole. Yet, with increasing governmental intervention and expectations in the planning and regulatory areas, it may become more critical to consciously engage in manpower planning and development, rather than leave the personal growth of administrative personnel entirely to chance and random factors. The need is to insure individual opportunity through a non-coercive counseling process. A further need is to provide at reasonable cost the appropriate educational opportunities to meet the recognized individual and system needs.

The issue of government subsidy of both health services administration pre-career and continuing education programs must also be raised but again, the data do not provide the answers. The knotty question involves the balance between individual and societal payment for education versus individual and societal benefit. It is perhaps not a question that hard data will ever answer, but more a question of values; as such, it may be a question best left to the political arena for decision making by public consensus. There is clearly a need for more research on defining health executives' performance and relating that performance to their pre-career and continuing educational experiences. Yet, the number of intervening, moderating, and interacting variables is so vast, that definitive answers are probably beyond hope.

The challenge in this area of subsidy is to develop a clear rationale based on some specific assumptions, and thus to clarify what the desired end-goals are. Pre-career education subsidies may be less of an issue for governmental policy change than is continuing education, given the American tradition of support of higher education. A rapidly changing environment may well justify subsidy of continuing education programs as well. Even then, however, the challenge is in determining which programs and/or which students to support, for how long, how often, and at what levels. The question, in a sense, returns to the question of individual motivation to engage in continuing education since subsidies may well affect individuals' decision-making. Unfortunately, we know much too little about the motivation toward self-renewal and development to really assess that question at this time.

In summary, then, the educational challenge is one of producing and maintaining well-rounded individuals for the administrative roles in the health care system--individuals with an understanding of society at large, of managerial skills, of the environment of the health care system, and of a specialized area of functional work. This challenge may well become more difficult as the health care system increases in complexity.

RESEARCH CHALLENGES

A number of questions arise from this project which should stimulate further research. There is a need for further research into the skills needed in different subsystems of the health system. Research into both direct service delivery organizations and the newly emerging planning-regulatory-evaluative agencies is appropriate. Further probing of both chief executive tasks and of the tasks of other administrative personnel would be helpful in better understanding the variety of skills appropriate in the health system. Comparative, broad scale research would be most helpful in better understanding administrative requirements.

Another major research question lies in understanding the impact of varying educational formats on different individuals for learning different skill and knowledge elements. At present, it is difficult to tailor programs to individuals or to subject matter requirements. Well designed and conducted research might begin to lead to such individualization, provided reasonable costs can be maintained.

More probing of the actual content of educational programs and the impact of the content is another research need. It is difficult to determine the true components of most instructional programs from the limited information available. Research into value transmission and development among potential and practicing administrators would also be useful. The goals of administrators vary by institutional type to some extent; yet, it is unclear if this variance is due to self-selection into particular institutional settings, or to characteristics of the institutions themselves. A better understanding of administrators' goals would assist in potential modifications of the overall state of the health system.

There clearly are many other research challenges arising from this project which are suggested throughout this report. No attempt to summarize them all is feasible in this concluding chapter. However, those research questions highlighted here seem most worthy of extensive further investigation.

BARRIERS TO ROLE IMPLEMENTATION

This chapter has described a number of challenges for the future involving both the health care system and its administrators. Barriers to role implementation are another area of concern examined in this section.

Whenever barriers are discussed, it is necessary at the very beginning to mention the twin problems of innovation and change. Basic to providing for innovation and change in any organization is overcoming the problem of tradition. There always will be those who establish their position on tradition. There can be no doubt that there are many traditions in the health care system. However, there are forces at work which will tend to reduce the impact of tradition. Among these are the public expectations for cost effectiveness and the energy shortage. However, tradition still remains as a barrier.

Chief executives' philosophy of administration may present another barrier to change. The basic values which individuals espouse may orient them toward an open system concept with a basic trial and error attitude toward major change. Others may follow a model of gradual incrementalism which is open to minor adjustments in direction, but not to major single-leap changes. Still a third philosophy may exist which essentially refuses to move from a pre-charted course. Administrative philosophy, the personal value-set, may be a major barrier to implementation of the future administrative role.

The prior experience of the individual is another area of concern. All individuals, including managers, respond to those stimuli which have been reinforced in the past. Thus, past experience must be an important determinant of future behavior. The administrator who has tried innovative strategies, who has undertaken leadership roles in inter-organizational coordination, who has developed cost-effective program proposals and who has been unsuccessful in implementation because of board, community, or staff resistance may be reluctant to try again. Individuals whose experience with change has been unfavorable will have problems with the future expanded innovative role.

Educational backgrounds may present another barrier to change. It is likely that many chief executives do not believe they have the skills to deal with change and, whether their perception is accurate or not, these supposed educational deficiencies must hinder their adaptation to the future. Acquiring or developing needed educational skills in an adequte depth when one has once achieved a chief executive position is especially difficult, given the many time demands of the position. Without a self-perception of adequate educational background, many individuals will be reluctant to implement the expanded chief executive role which is anticipated in the future.

Despite the increasing unity of effort between related health care groups, some inter-organizational and intra-organizational conflict still exists. A related concern is the problem of changing community concepts of the health administration role. With increased demands for health care services, health care institutions, for instance, may generate increased traffic flows and not be welcome in a community due to serving more clients. This problem, along with similar developments, has added to the external components of the chief executive role so that the chief executive no longer can be solely inward looking in terms of the internal operations of the health care facility. For some chief executive officers, there are barriers of tradition, philosophy, experience, and education to achieving the expanded role.

There are other barriers, relative to the understanding of the role sent by the role senders to the chief executive officer. In some instances, there are conflicting sent roles from the planning agency, board of trustees, and community leaders. Some chief executive officers have to deal with role overload, which may place the chief administrator increasingly in situations where he or she is unable to perform at all adequately the assigned role. It should be pointed out that these situations can be relieved, although there is the "turf-protecting," grass roots attitude that many establish to deal with such untenable situations and resulting barriers.

In the final analysis, no organization or individual can be all things to all people. It is necessary to sort out priorities, establish goals, and implement policies if the barriers are to be overcome successfully by chief executive officers.

RECOMMENDATIONS

In most research situations, data do not provide recommendations. However, in the present instance, many recommendations were offered by those interviewed. This section will review some of the suggestions.

Many comments were made about the educational process itself. There was general agreement that financial support was needed to continue the various educational programs in health services administration. This belief was true for graduate and undergraduate programs as well as for continuing education. In fact, many believed more attention must be given to continuing education and its support.

Related to the financial support of programs were the suggestions for continual faculty updating. Some of the suggestions included fellowships for faculty, part-time administrative positions, and means for regular contact between educators and administrators. Another suggestion was the rotation of faculty through various health institutions on a regular basis. No doubt, the costs of such approaches tend to be unusually high. However, many of the subjects of the project believed such field contacts were most important and necessary.

It was thought that health services administration programs should pursue their continuous program content review, and that such content review should not overlook the input of practicing administrators. Attention should be directed toward skill development,including financial and interpersonal skills and the ability to recognize and assess needs for change. At the same time, it was recognized that administrators should never lose sight of, not only the health care system, but the total social system. Otherwise, they can never adequately cope with the needs of society.

Continuing support should be given to the cooperative efforts of the various units in the health care system at the grass roots level, especially in light of continuing needs for cost effectiveness. Related to this suggestion is the necessity of easing transitional changes. As controls are exercised or relaxed, educational efforts are needed to relieve the stress of such changes.

SOME FINAL THOUGHTS: FROM THE RESEARCHERS' PERSPECTIVE

In preceding sections of this report we have attempted to maintain a studied distance between the research data and our own impressions of that data, reporting and interpreting as objectively as possible. However, as must happen with any research project, the investigators collect a number of impressions--some reinforced many times and others representing more isolated observations and implications. In this section we review a number of these personal observations with the caution that they represent our judgment of issues of major significance after immersion in the research for an extended time.

Of primary significance are the four major components in the education of a health services administrator involving: 1) a well-rounded and extensive understanding of the social, political, and economic environment and institutions of the nation; 2) a thorough acquaintance with the health care system; 3) training in managerial skills, some of which may be unique to the health care system itself, such as relationships with third party payers; and 4) development of an area of specialization. Considerable debate presently exists as to whether or not a specialty is necessary; however, as health care institutions become larger and if they continue to utilize the corporate model, entry level jobs for potential administrators will increasingly require an administrative speciality skill in areas such as finance, accounting, purchasing, personnel, etc.

A repeated theme is the need for continuing education. There are two major components of continuing education programs for administrative personnel. One component requires general educational development to deal with long range problems and situations. Traditionally universities and colleges have demonstrated competence in this area, but opportunities for educational development programs in an off-campus mode are also needed. Home study, modular scheduling, evening classes, and so forth are all possible formats; yet continuing research is necessary to develop and evaluate the most effective programs.

The second component of continuing education includes educational programs pertaining to current events and issues. In many situations the professional associations may be the best vehicles for this type of educational development. Clearly there is a need for those involved with continuing education to work more closely together whenever possible.

A major concern is the motivation of administrative personnel to participate in continuing education programs. More research is needed to determine the pay-off from these programs in cost-benefit terms. Once these basic determinations are made, it will be possible to develop the necessary incentives to enhance participation. In the absence of research studies, some form of traineeships for continuing education may be a point of departure. Another problem requiring investigation is time availability. Chief executive officers find it difficult to be absent for an extended period or for a set sequence of time periods. Educational delivery systems must be developed to alleviate the time commitment problem.

As more emphasis is placed on the corporate model in the health care system, graduate programs should review course content to determine whether or not changes are needed to accomodate the model. In addition, further research is needed to determine the effect of the corporate model on the role of the chief executive officer. At the very minimum, one would expect more emphasis upon strategy and decision making skills. No doubt more emphasis upon quantitative aspects including mathematics will also be necessary.

The increased emphasis on the external role of the chief executive officer indicates a need to look more specifically at the skills required to perform this role, to determine if they can be taught, and, if necessary, to rearrange the curriculum of health services administration and continuing education programs to develop these skills. Requirements for negotiating, liaison, planning, public relations, and political skills are on the increase. The bases of these skills can be developed in graduate level programs, but further refinement will be an individual responsibility developed in the work setting itself.

Facilitating coordination, cooperation, and integration of health care system units must become a critical concern in the years ahead. There is much discussion of alternative forms of organizing health care delivery, but there are also great difficulties in the implementation of major changes. Vertical and horizontal integration, mergers, satellites, and other combinations are readily considered, but not so readily achieved. Deriving maximum benefit from the resources devoted to health will be difficult, and will require health administrators at all levels to work cooperatively toward that goal.

More community involvement will change the role of the chief executive officer and his administrative staff. The chief executive officer's greatest area of expertise will be that of a generalist, but he will need increasing numbers of administrative specialists with technical backgrounds. The supervisory skill development, as opposed to the technical training, of these middle management personnel must become an issue of increasing concern as they grow in numbers. Continuing education and effective modes of training for middle management supervisory personnel will probably receive similar attention within ten years to that now given chief executive officers.

The technical training of staff specialists in finance, personnel, planning, systems engineering, marketing, and other areas is presently emerging as an area of concern. Many administrative staff specialists will come from undergraduate programs, at least initially. Some, such as financial staff, may increasingly require master's level attainment. These staff specialists will be in increasing demand to meet the administrative requirements of health care systems organizations. As the trend develops for students to acquire work experience prior to entering graduate school, these administrative positions will provide a background for advanced level administrative education. A trend may also develop for those with patient care backgrounds to seek advanced level administrative training.

Perhaps our most complex observation should be our last. The uniqueness of health care administration as an educational track and as an occupation needs further attention. There clearly are features which distinguish health care from other industries and even from public administration. The twin requirements of internal organizational management and external community representation are distinguishing characteristics. The complexity of the medical technology managed and of the financial mechanisms employed are other characteristics as are the number and extent of organizational relationships with which the health executive must deal. The unique characteristics of health services administration must be clearly identified and form the focus for health services administration programs of both pre-career and continuing education forms.

CONCLUDING COMMENT

All in all, in the opinion of executives and role senders involved in this research effort the health care system is indeed adjusting to the changing social and economic situation. Chief executive officers as well as their administrative staffs, are also accomodating to these changes. However, the stresses and strains of such changes can be minimized through various educational assistance programs and especially through continuing education. To the extent that these and other cooperative efforts are developed and maintained, innovative changes will be formulated such that the health care needs of citizens can be adequately and effectively met.

APPENDIX A

METHODOLOGY: THE RESEARCH QUESTIONNAIRE

One of the data collection strategies for the research project utilized a mailed questionnaire which was distributed to a national sample of health services administrators. The overall response rate for this questionnaire was approximately 40%. It appears that the hospital administrator respondents to the questionnaire fall within the known bounds of the distribution of all hospitals in the United States based on comparisons of data for bed size, census, and numbers of employees. Details regarding questionnaire development, sample selection, and the sample respondents are described in the sections which follow.

QUESTIONNAIRE DEVELOPMENT

The questionnaire utilized in the research project resulted from extensive developmental work. This developmental work occurred over a period of about six months, beginning with project initiation in November 1974, and concluding in April 1975 when the questionnaire was submitted for approval to the Department of Health, Education and Welfare and the Office of Management and Budget.

The early and initial drafts of the questionnaire included a wide variety of potential approaches to developing data on the role of the chief executive officer in health care institutions. These early drafts in essence were collections of materials and questionnaire approaches which had been used in other research projects. In addition, institutional data on the hospital and personal background data on its administrator were included in these early drafts.

A number of differing role approaches were employed in the preliminary drafts, including previous work which had focused on role relationships among different personnel, on role conflict and ambiguity, and on particular task requirements of a role. Questions related to the goals or values of the respondent, questions about particular role senders' influence, and about innovation in health services institutions were all included in these preliminary drafts.

The most extensive preliminary draft of the questionnaire was twenty-three pages long. It was obvious to the research staff that a questionnaire of this length would draw a poor response. Thus, a process of sifting and winnowing was undertaken to reduce the questionnaire to a manageable size; to focus on the key issues of the project; to encourage an adequate response rate; and to insure speedy governmental approval of the questionnaire under both Agency and Office of Management and Budget auspices. This process of sifting and winnowing was greatly aided by the willing effort of a number of individuals and groups who consented to review the questionnaire at various stages of development. In some cases, more than one draft of the questionnaire was reviewed by these individuals.

Among the reviewers of the preliminary draft of the questionnaire were the members of the Project's Advisory Committee who met in January 1975 for an all-morning review and discussion session regarding the project's approach to its areas of interest. Also in attendance at this meeting of the Project Advisory Committee was Mr. William Holland of the Department of Health, Education, and Welfare, Project Officer for the research project. Extensive discussion, recommendations, and a revision of the questionnaire flowed from this meeting of the Project Advisory Committee.

A second major group to participate in a review of the questionnaire were several members of the Wisconsin Southern Hospital District who were asked at their February, 1975, meeting to complete and/or review the questionnaire to assist in its development. Again, given the feedback from these individuals, revisions were made in the questionnaire format, and certain areas of the questionnaire were deleted or reworked to provide more clear cut information.

Also, at approximately this same time, a detailed review of the questionnaire was provided by Mr. William Holland, Project Officer for the contract, and Mr. David Hoover, Associate Director for Program Planning and Evaluation, both of the Department of Health, Education, and Welfare. The comments provided by Mr. Holland and Mr. Hoover were of special assistance in preparing the questionnaire for eventual governmental review and clearance. They specifically identified questions which had a weak purpose; which were inappropriate for a governmental survey; which needed clarification and refinement; or which were too general or not especially useful for the purposes of the research. Again, substantial revisions in the questionnaire were made following this review.

The questionnaire at this point was again submitted to a number of individuals for their completion and/or evaluation. The questionnaire was also submitted to Dr. Harry Sharp of the Wisconsin Survey Research Laboratory for his professional evaluation. After these various refinements and revisions, the questionnaire was finally submitted to the Office of Management and Budget Clearance process in April, 1975. The version submitted was approved for distribution in March, 1976. Copies of the four forms of the questionnaire appear as Appendix B.

In the process of revision of the questionnaire from the preliminary to the final draft, and in preparation for Office of Management and Budget approval, it became clear that a precise statement of the questionnaire's purpose was essential. In its most concise form, the purpose was stated specifically as the development of data on the role of the chief executive position in health care institutions. More completely, the questionnaire's purpose was to develop data on such issues as:

1. The influence of "role senders" upon patient care program development and anticipated changes in this influence;
2. The importance of various goals for the administrators' institutions;
3. The types and extent of innovation in patient care and in management programs, and
4. The functions, roles, and activities of administrators.

In addition, for purposes of analysis, personal background data and institutional background data were collected in the questionnaire. In general, administrators were asked to respond in terms of their present state on the various major questions and also in terms of the changes which they anticipated in the future in relation to these questions. This format was designed to assist in understanding where administrators of institutions with varying characteristics are at present, as well as to understand how and in what different ways changes are anticipated across different types of institutions.

A continuing concern over the length of the questionnaire, and over the influence of questionnaire length on response rates, led to the development of three separate forms of the questionnaire to be distributed to hospital administrators. These separate forms were identical except for pages four and five. Pages four and five of questionnaire form 1 asked a series of three questions about managerial activities which the administrator engaged in. The questions focused upon the time, the importance, and the anticipated importance of each of the managerial activities. Respondents were asked to classify these activities from least time-consuming to most time-consuming in terms of a forced distribution of the activities. Questionnaire Form 2 utilized a similar format for a set of managerial role descriptions derived from Mintzberg (1973). Questionnaire Form 3 was entirely different from forms 1 and 2 in that it listed a series of 47 different task activities which are generally recognized as requiring managerial performance. Respondents were asked to identify how these tasks were divided in their institutions. The options available for response included four categories:

1. Perform directly;
2. Accomplish indirectly;
3. Performed by others, and
4. Not performed.

It was felt that information from all three questionnaire forms was desirable to obtain from the administrative respondents, but it seemed clear that a questionnaire which contained all three forms within itself would not receive an adequate response rate. Thus, the determination to utilize the three separate questionnaire forms was made. In addition, the research team anticipated that the task activities check list, questionnaire form 3, would be more difficult and more time-consuming for respondents to complete. In an attempt to reduce the impact of this supposedly more difficult form on the overall response rate, it was determined that the sampling strategy utilized would direct questionnaire forms 1 and 2 each to forty per cent of the respondents, while questionnaire form 3 would be sent to only twenty per cent of the respondents. As noted in the discussion of sample respondents below, this original hypothesis about the difficulty of questionnaire form 3 was not in fact born out, and questionnaire form 2 appears to have been more difficult to complete.

Other Health Services Administrators

Part of the research project goals included the study and the comparison of hospital administrators with administrators of other types of health care institutions. To accomplish these goals, the project staff determined that it was appropriate to send a survey questionnaire of a similar nature to administrators of other health services institutions, including long term care facilities, clinics and health maintenance organizations. Modifications were made to the hospital administrators' survey instrument so that the instrument would be appropriate for administrators of other health services institutions. To the fullest extent possible, questions were left unchanged between the hospital administrators' and the other health services administrators' questionnair

Changes were limited to substitution of the word organization, for the word hospital, or to clarification of information regarding, for example, the facility's size when this would not appropriately be measured in bed size terms. A detailed comparison of questionnaire forms 1, 2, and 3 with the questionnaire form for other health services administrators shows that questions 4, 5, 6, and 7 received clarifying changes. Question 9 omitted two inappropriate role senders for non-hospital health services administrators. Other major changes in the questionnaire involved combining questionnaire forms 2 and 3 to distribute to the other health services administrators. That is, other health services administrators were asked the questions about managerial role descriptions and the questions about task activities within their institutions. They were not asked the questions which appeared on pages 6 and 7 in questionnaire forms 1, 2, and 3; these questions related to innovations in patient care programs and to innovations in management programs. It seemed clear that both patient care programs and management programs which might involve innovations in a hospital setting would be quite distinctive from those programs which might be undertaken in these other health services institutions. Thus, it was determined simply to eliminate those questions related to patient care and management program innovation.

Thus the questionnaire submitted to other health services administrators was in large measure identical in substance to the questionnaire distributed to hospital administrators, with changes essentially being made in terms of particular wording of questions to make them more applicable to these differing settings. One change should be noted on the questionnaires to other health services administrators which causes an apparent anomaly in the tables of data tabulations. The other health services administrators' questionnaire contained a typographical error in question 38 of the task activities section. The error involved the omission of parentheses in which the respondents placed their check marks and caused a very low response rate for this question, which asked about "the coordination of maintenance activities." The shrinkage of information available due to this typographical error does not cause serious damage to the interpretation of the study.

SAMPLE SELECTION

The original data collection plans for the research project limited the area of respondent sampling to seven Midwestern states: Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, and Wisconsin. The purpose of this limitation, which was instituted at the request of the Federal Government (the funding agent for the contract), was to avoid duplication and repeated contacts with the same subject population. The initial concern was that there would be overlapping inquiries with other research projects. The original sample of respondents was thus selected on this basis. At a subsequent point, the initial Federal request was modified to suggest that a national sample would be more productive from the point of view of the government. It was finally determined that more extensive sampling should occur in the original seven

Midwestern states, but that the potential respondent universe should be expanded to include the entire United States. Thus in effect two separate sampling strategies were used: one for the Midwestern states of Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, and Wisconsin; and a second one for the remaining states.

The principal focus of the study was upon hospital administrators, however it also seemed appropriate to develop comparative data on other health services administrative personnel. Thus, in addition to hospital administrators, long term care facility administrators, clinic managers, and HMO managers were also sampled. The universe of long term care facility administrators, clinic managers, and HMO managers is less clearly defined than the universe of hospital administrators. Thus, the sampling strategy for these latter three groups of health services administrators is not as clear cut, nor perhaps as representative of the total population as one would wish. Unfortunately, population characteristics are not clearly definable and thus it is difficult to precisely determine the representativeness of these samples of other non-hospital administrators.

Since in essence there were four populations of health services administrators sampled in the research, the sample selection procedure for each group will be described separately.

Hospital Administrators

The potential respondent universe of hospital administrators for the questionnaire was identified from the American Hospital Association (1975) Guide to the Health Care Field. This Guide to the Health Care Field is an annual publication which contains lists of health care institutions by state. These lists are arranged alphabetically by city with all hospitals in a city arranged in alphabetical order under the city name. Various descriptive data about the hospitals are provided, including such information as the type of control of the hospital, and the bed size of the hospital. A principle advantage of using the American Hospital Association (1975) Guide to the Health Care Field to develop a survey mailing list is that complete hospital address information is provided. In addition, the guide is updated annually, and in most cases errors or other changes in hospital status would be noted on an annual basis. Furthermore, the Guide Issue data provide comparative information for assessing the representativeness of a sample.

As noted above, two sampling strategies were utilized for selecting potential respondents from the universe of hospital administrators. In the seven Midwestern states (Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, and Wisconsin) all non-federal hospitals reporting over fifty beds in the 1975 edition were selected. Mailing labels for these institutions were prepared and were addressed to "Chief Executive Officer." Outside of these seven states, a simple one-in-four sample of all non-federal hospitals over fifty beds was selected from the remaining forty-one contiguous states. Again, the purpose of the two different sampling strategies was to meet a change in the requirements of the research project by the funding agency.

Within the seven Midwestern states, personal contact was made with State Hospital Association Executive Directors in each state. Most of the executives expressed interest in the project, and indicated that they would provide favorable notice for the project in their Association Newsletter, or that they would refer the research questionnaire to their Association's Research Review Committee for its consideration. Substantial problems with these Association contacts were encountered in only one state. This particular Association required nine months to respond to an initial request, and finally submitted the questionnaire to its review committee after the distribution had actually occurred. As had been anticipated, this association did not approve the request, and a number of comments were received from hospital administrators in the state to the effect that they did not answer questionnaires which were not approved by their state association.

In other states, we also discovered that in addition to state association approval, some areas required the approval of a regional council, and others required the approval of a city cr metropolitan hospital council. The effect of association endorsement on response rates is unclear, in part because of these requirements for regional or local endorsement (as well as state association endorsement) and in part because of the substantial time delay which occurred between the association contacts and final approval, clearance, and distribution of the questionnaire.

Shortly before the distribution of the questionnaire to the non-Midwestern states, a letter was sent to the State Hospital Associations in each of these states, indicating that a questionnaire distribution would occur and noting that we were providing the state association with a copy for its information. No initial attempt was made to gain the endorsement of state associations in the non-Midwestern states. A limited number of state hospital associations replied to this letter requesting more information or expressing their interest in supporting the research project. If more information was requested, it was provided by the research staff.

Long Term Care Administrators

The universe of long term care administrators is difficult to define because there are approximately 25,000 long term care facilities in the United States. In addition no comprehensive listing of these facilities is available. Thus it was determined that the most appropriate definition of the long term care administrators' universe would be at best a compromise. The American Hospital Association's (1975) Guide to the Health Care Field contains a list of accredited long term care facilities published by the Joint Commission on Accreditation of Hospitals. This list was used to define the universe of long term care facilities whose administrators would be sampled for the research project. It is likely that these facilities are, on the average, of higher quality than all long term care facilities. Thus the sample is not representative of all long term care administrators. On the other hand, an argument can be made that administrators of such accredited facilities may be leaders in the provision of long term care services in their area, and that the opinions and perceptions of these individuals regarding the field of long term care administration may be more useful in identifying issues, problems, and anticipated changes in the field for the future.

Again, two sampling strategies were utilized for long term care administrators: one for the original seven Midwestern states, and a second strategy for the remaining states. This dual strategy resulted in a heavier sampling of facilities in the Midwest. For the seven Midwestern states, all accredited long term care facilities listed in the 1975 Guide to the Health Care Field which were not operated by a hospital or psychiatric facility were considered potential candidates for the universe. Given those long term care facilities which are non-hospital and non-psychiatric, the research staff attempted to find addresses for those facilities. Finding current addresses for long term care facilities presented more problems than originally had been anticipated, and thus some of the facilities for which addresses could not be found were eliminated from the sample.

For the non-Midwestern states, a random sampling strategy was used, and successive passes through the listing were made until an adequate number of facilities for which addresses could also be found was secured. It is thus inappropriate to claim a clear-cut representativeness for the long term care facilities' sample. It is unclear what universe one can generalize about from the sample of respondents. One bias, as noted before, is the fact that the sample included only J.C.A.H. accredited facilities. A second bias is that the source book for addresses was published in 1970, which suggests that these are facilities which have been in existence for some period of time. Again, however, these biases may not be significant for the purposes of the sample and questionnaire in that the biases suggest that the facilities are more stable and in turn that the administrative personnel may also be more stable and more capable of predicting future changes in their field.

Clinic Managers

For clinic managers only one sampling strategy was utilized in that only the original seven Midwestern states were sampled. This strategy seemed appropriate given the recent survey by the Medical Group Management Association which was funded by the Bureau of Health Manpower and was conducted by the Center for Research in Ambulatory Health Care Administration. It did not seem appropriate to resurvey the same administrators on similar material. Thus, the sample of clinic managers was limited to the seven Midwestern states.

The International Directory of the Medical Group Management Association 1974-75 Edition was utilized to define the universe of potential respondents within the seven states. The following criteria were also imposed on the sample selection of clinic managers. The Directory had to indicate:

1. That the clinic had a manager and five or more full-time doctors, and
2. That the clinic had responded to the Medical Group Management Association Directory.

Medical Centers at Universities--that is, campus health centers with many part-time physicians--were also eliminated from the sample. Given these criteria, all remaining clinics were numbered on a state-by-state basis, and a table of random digits was used to select those clinics which were to be included in the sample. The number included from each state was determined by the percentage of the total eligible clinics which that state represented in the seven states, and by the desire for a total clinic manager sample of seventy units. Using this methodology and the Medical Group Management Association Directory, a sample of seventy clinics was selected.

Health Management Organization Administrators

A list of operational health maintenance organizations is regularly developed by an organization called Interstudy based in Minneapolis, Minnesota. This list of operational HMO's was used to select a small sample of health maintenance organization administrators. Again, this sample was limited to the seven Midwestern states. Obtaining addresses for these health maintenance organizations was generally done either by consulting telephone directories, or by attempting telephone calls to the organizations to solicit their addresses. In some cases, no address could be found or no record of the organization seemed to exist in the city where it was supposed to be located. Again, this sample is probably not representative of all health maintenance organizations.

There is some disagreement about a practical definition of a health maintenance organization, and in fact some organizations which are listed as operational HMO's in the Interstudy guide are in fact insurance programs by their own definition. An additional problem with the sample of HMO administrators is that subsequent to sample selection, but prior to questionnaire distribution, a number of these administrators were interviewed in another phase of the research project; thus, the sample was reduced from its original number. It is unclear what universe the sample of HMO administrators represents, although the same propositions presented regarding long term care administrators may apply here. Those sampled tend to be administrators of HMO's which have a relatively long history and which are relatively well known--which in turn may make these administrators better able to predict the future of the HMO administration field.

SAMPLE RESPONDENTS

All administrators in the samples selected were initially mailed a cover letter explaining the study, their appropriate questionnaire and a business reply envelope. Approximately three weeks after the first mailing all non-respondents to that time were sent a second questionnaire, business reply envelope and a cover letter again requesting their assistance. Finally, three months after the first distribution of questionnaires, a third mailing was made to a one in five sample of non-respondents at that time. This third and final follow-up yielded an additional 24 usable responses out of 250 questionnaires mailed. Based on the low response rate to this third follow-up it was determined that additional mailings to the remaining non-respondents would not be cost effective. Furthermore some preliminary calculations indicated that the respondents apparently were representative of the entire sample universe.

Hospital Administrators

As noted in the discussion of questionnaire development above, the questionnaire sent to hospital administrators had three forms which were identical except for pages four and five. Table A-1 shows a summary of questionnaires distributed and usable returns received by state and by question form. As noted in the discussion of sample selection, substantially more questionnaires were distributed to seven Midwestern states than through the remaining states. The per cent of usable returns varies from 66.7%

in New Hampshire to no returns from Nevada and North Dakota. The bottom line of Table A-1 lists the percentages of each questionnaire form sent and the percentages of usable returns which each questionnaire form represented. As noted before, questionnaire forms one and two were each distributed to approximately 40% of the sample, and questionnaire form three was distributed to 20% of the sample. The response rate for questionnaire form one also represents approximately 40% of the sample, but the response rate for questionnaire form two was slightly lower than 40%. In retrospect, this lower response rate for questionnaire form two may have been due to the introduction of new terms into the administrators' vocabulary. The role descriptions utilized, being unfamiliar, may have generated this lower response rate.

The overall response rate for the entire sample based simply upon usable returns and the total number of questionnaires sent represents a 36.6% usable returns response rate. It may be appropriate to adjust this response rate in one of two ways, since Table A-2 shows that 83 questionnaires were returned which were unusable for a variety of reasons, including such things as "Moved--left no address" messages from the post office, hospitals in bankruptcy, hospitals which had closed, or hospitals in which the administrator declined to participate because of demands on his time. Two adjustments to the response rates are possible. One could take the 755 usable returns and to these add the 83 unusable returns for a total of 838 questionnaires which elicited some response. These 838 questionnaires represent 40.6% of the number of questionnaires mailed. Alternately, one could subtract the 83 unusable returns from the number sent, with the concept essentially being that these questionnaires were not effectively distributed. In this case, one could note an effective number of questionnaires sent of 1,982 (i.e., 2,065 - 83); then, the 755 usable returns represent 38.1% of this base. Thus, depending on how one wishes to treat unusable returns, the questionnaire response rate varies between 36.6% and 40.6%.

Given this response rate of approximately 40%, the question must be asked "How representative of the entire universe of non-federal hospitals of over 50 beds in the 48 contiguous states are the respondents." Tables A-3 and A-4 present bed size data from the American Hospital Association's Hospital Statistics, 1976 Edition. Table A-3 presents bed size data as reported in Hospital Statistics, while Table A-4 aggregates this data into small, medium, and large hospital categories. Tables A-5 and A-6 present the total sample respondents observed and compare the total sample response with the percentages which would be expected, based upon the data of Tables A-3 and A-4. From this observed and expected data for the entire universe of United States hospitals, Chi Square values have been calculated. These Chi Square values indicate that the hypothesis, that the sample distribution is similar to the universe distribution of hospitals, may not be rejected. In other words, the Chi Square values indicate that the sample does not significantly differ from the population in the distribution of respondents. Similar Chi Square statistics comparing the sample respondents with the universe population have been computed for each questionnaire form. These statistics are presented in Tables A-7, A-8, and A-9 for the three bed size groups. In all cases, the Chi Square values are such that one may be reasonably confident that the number of sample respondents in each bed size category accurately reflects the number of potential respondents in the universe.

Based on the data in Hospital Statistics, it is also possible to compute a number of other comparative measures of the sample respondents versus the universe. Particular areas of concern include the average bed size, the average daily census, and the average number of personnel. Tables A-10 through A-21 present t-test comparisons based on the average data by hospital size category from the American Hospital Association's (1976) Hospital Statistics and from the sample data. Data are presented separately for each questionnaire form and for all hospital administrator respondents together.

While Tables A-5 through A-9 used a Chi Square statistic to assess the comparability of the overall distribution of respondents to the overall population distribution, Tables A-10 through A-21 focus upon differences within bed size categories between the AHA data and the sample data by comparing mean values within these bed size categories. The t-test is a different estimator than the Chi Square test, but is subject to the problem of identifying statistically significant differences which may not be of practical significance. This distinction between statistical and practical is important because the t-value is influenced by the standard deviation and the sample size employed in the test as well as by the actual magnitude of the difference between means. Thus, a statistically significant t-value may have little practical relevance. A real difference in means of 10 to 20% may be practically significant while a difference smaller than that is probably not practically significant.

Tables A-10, A-11, and A-12 indicate that there are no statistically significant differences for questionnaire form 1 for average bed size, daily census or personnel. Tables A-13, A-14, and A-15 indicate that there are two statistically significant differences for questionnaire form 2, one for average bed size and one for average daily census. In both cases these differences occur in the largest size category and are of such magnitude that they are practically significant. In a sense the difference for average daily census is a direct result of the bed size difference since census is, to some extent, a function of beds. It appears that questionnaire form 2 received a lower response from hospital administrators of larger hospitals, especially those over 500 beds. Overall, however, as the Chi Square value of Table A-8 shows, the respondents to this form do represent the universe. Another possible explanation for the difference of means in the 300+ beds category is that 23 of the 26 Midwestern hospitals interviewed, and thus not sent questionnaires, were in this category and may have reduced the mean.

Tables A-16, A-17, and A-18 provide comparative data for questionnaire form 3. Table A-16 indicates that there is one significant difference for the average bed size data in the 300+ beds category. Again the interviews with large Midwestern hospitals and difficulty in completing the form may be plausible hypotheses to explain this difference. Tables A-19, A-20, and A-21 provide comparisons of the AHA data with all hospital administrators who responded to any questionnaire form. Three statistically significant t-values are found in these tables. The average bed size and average daily census differences in the 300+ beds category follow from the differences found for questionnaire forms 2 and 3 in that category. The average daily census difference in the 50-99 beds category represents a real difference of two beds and is not practically significant.

Thus, for three hospital characteristics, the three questionnaire forms and the total respondent set, and for the three hospital size categories, six significant differences exist in the data; that is, of thirty-six comparisons, there are six significant differences. On the whole, the data appear to be representative of the universe. The differences which do exist between the sample data and the AHA data are not excessive, given the interviews conducted with large Midwestern hospitals. It should also be noted that the AHA mean data were calculated using all hospitals in the United States, which includes Federal hospitals. These Federal Hospitals were specifically excluded from the sample but the data in Hospital Statistics are presented in such a way that it is impossible to exclude Federal hospitals from the average data by bed size category. Given this fact, and the number of differences in means which do appear significant, it seems reasonably safe to assume that the sample is generally quite representative of all United States hospitals.

As part of their questionnaire response, the respondents were asked to send a copy of their job descriptions, if these were available. Eighty-three percent of the hospital administrators indicated that they had a job description; however, only 19% of them sent job descriptions with their questionnaires. Thus, the question may be asked again, "Do those respondents providing job descriptions accurately reflect the universe of hospital administrators?" Table A-22 presents statistics on those providing job descriptions. It appears from these data that the respondents do accurately reflect the universe--at least in terms of representing adequately the various hospital size categories. The Chi Square statistic of 2.99 in Table A-22 shows that the hypothesis, that the sample accurately reflects the universe distribution, may not be rejected. Thus, we may feel reasonably confident that the hospital administrators providing job descriptions are representative of all hospitals.

On the whole, it seems clear that the sample statistically reflects the universe of hospital administrator respondents, both in total, and for each of the separate questionnaire forms. Thus, it is relatively safe to generalize from this sample and to make statements about hospital administrators in the United States in general based on the data collected from this questionnaire in each of its forms.

Other Health Services Administrators

Other health services administrators include administrators of long term care facilities, clinic managers, and HMO administrators. The questionnaires distributed to these groups were all of one form and contained minor changes to make the questionnaires more applicable to these groups as noted in the discussion of questionnaire development above. The questionnaires distributed and the usable returns received by state are listed in Table A-23. As noted in the section on sample selection, clinic managers and HMO administrators were sampled only in the seven Midwestern states, and long term care administrators were more heavily sampled in the seven Midwestern states than in the rest of the country. The bottom line of Table A-23 lists the per cent usable returns for each category of administrator. The long term care administrators had the lowest response rate of the three groups. Taking all of these other health services administrators together yields a response rate of 35.5% for the 188 responses and 529 questionnaires distributed. This response rate does not appear to be greatly different from the overall response rate for hospital administrators. Given the difficulty of defining the universe for each of the three categories of these other administrators, and the unavailability of data on even those portions of the universe which were sampled, no comparisons by bed size or by other factors are feasible. At best, it may be safe to say (given the sampling strategy) that the returns are generalizable to the universe of A.H.A. listed and J.C.A.H. accredited long term care facilities and to clinic managers in seven Midwestern states. However, even this statement must be based more upon a belief in the efficacy of sampling procedures than upon any demonstrable comparisons with this subset of the universe.

SUMMARY

This appendix has discussed the development, approval process, sample selection, distribution, and response characteristics of the questionnaire utilized as a data collection instrument in meeting the objectives of the contract.

A question always asked in survey research is whether or not the responses represent the universe from which the sample is drawn. Sample theory posits the principle that a properly drawn sample will represent the universe, but in most research efforts this proposition is not tested because some basic dimensions of the universe are unknown.

In this specific questionnaire survey dimensions of the universe of hospitals were identified in the American Hospital Association's *Hospital Statistics*, 1976 Edition. Utilizing these dimensions and the Chi Square Goodness of Fit test, it was concluded that the responses do represent the hospitals in the universe. Insofar as the administrators should also be representative of representative hospitals, we believe their responses are indicative of responses expected from the universe in total and hence the results can be generalized.

TABLE A-1

QUESTIONNAIRES DISTRIBUTED AND USABLE RETURNS RECEIVED BY STATE

	QUESTIONNAIRE FORM 1		QUESTIONNAIRE FORM 2		QUESTIONNAIRE FORM 3		TOTAL		
	SENT	USABLE RETURNS	SENT	USABLE RETURNS	SENT	USABLE RETURNS	SENT	USABLE RETURNS	PER CENT USABLE
ILLINOIS	99	31	97	25	50	21	246	77	31.3%
INDIANA	47	21	46	18	23	15	116	54	46.6
IOWA	38	19	37	14	19	8	94	41	43.6
MICHIGAN	78	29	79	27	41	19	198	75	37.9
MINNESOTA	47	21	48	17	24	10	119	48	40.3
MISSOURI	55	20	53	16	28	9	136	45	33.1
WISCONSIN	58	30	55	34	27	15	140	79	56.4
ALABAMA	11	2	10	1	5	2	26	5	19.2
ARIZONA	4	2	4	3	2	0	10	5	50.0
ARKANSAS	6	0	7	0	3	1	16	1	6.3
CALIFORNIA	50	17	49	11	25	6	124	34	27.4
COLORADO	5	3	6	2	3	2	14	7	50.0
CONNECTICUT	6	3	5	1	3	2	14	6	42.9
DELAWARE	1	1	2	0	0	0	3	1	33.3
DIST. OF COL.	2	0	1	1	1	1	4	2	50.0
FLORIDA	19	3	19	8	10	7	48	18	37.5
GEORGIA	12	3	12	3	5	2	29	8	27.6
IDAHO	2	1	2	1	1	1	5	3	60.0
KANSAS	9	3	9	3	4	2	22	8	36.4
KENTUCKY	9	4	9	4	4	0	22	8	36.4
LOUISIANA	10	2	10	3	5	2	25	7	28.0
MAINE	4	3	3	0	2	0	9	3	33.3
MARYLAND	6	3	7	3	3	0	16	6	37.5
MASSACHUSETTS	17	4	17	6	9	3	43	13	30.2
MISSISSIPPI	7	3	7	2	4	1	18	6	33.3
MONTANA	3	2	2	0	1	1	6	3	50.0
NEBRASKA	5	0	6	3	2	1	13	4	30.8
NEVADA	1	0	1	0	1	0	3	0	0.0
NEW HAMPSHIRE	3	2	2	1	1	1	6	4	66.7
NEW JERSEY	12	4	13	5	7	1	32	10	31.3
NEW MEXICO	4	3	3	2	1	0	8	5	62.5
NEW YORK	36	11	37	9	19	5	92	25	27.2
N. CAROLINA	14	6	13	5	6	2	33	13	39.4
N. DAKOTA	2	0	3	0	1	0	6	0	0.0
OHIO	22	8	22	10	11	5	55	23	41.8
OKLAHOMA	8	3	8	3	4	4	20	10	50.0
OREGON	5	2	5	1	3	1	13	4	30.8
PENNSYLVANIA	29	7	29	8	15	9	73	24	32.9
RHODE ISLAND	2	0	2	0	1	1	5	1	20.0
S. CAROLINA	7	3	6	2	3	1	16	6	37.5
S. DAKOTA	2	0	2	1	1	0	5	1	20.0
TENNESSEE	11	6	12	2	6	2	29	10	34.5
TEXAS	31	9	31	12	15	4	77	25	32.5
UTAH	2	1	2	0	1	0	5	1	20.0
VERMONT	2	1	2	0	1	0	5	1	20.0
VIRGINIA	11	3	11	3	5	3	27	9	33.3
WASHINGTON	8	2	8	5	4	2	20	9	45.0
WEST VIRGINIA	6	4	6	0	4	2	16	6	37.5
WYOMING	2	1	1	0	0	0	3	1	33.3
ALL STATES	830	306	821	275	414	174	2,065	755	36.6
PERCENT OF TOTAL	40.2%	40.5%	39.8%	36.4%	20.0%	23.1%	100.0%	100.0%	

TABLE A-2

QUESTIONNAIRES RETURNED WHICH WERE UNUSABLE

	QUESTIONNAIRE FORM 1	QUESTIONNAIRE FORM 2	QUESTIONNAIRE FORM 3	TOTAL
ILLINOIS	5	6	0	11
INDIANA	1	1	1	3
IOWA	1	0	0	1
MICHIGAN	4	5	3	12
MINNESOTA	1	2	3	6
MISSOURI	1	1	0	2
WISCONSIN	1	1	1	3
OTHER STATES	18	16	10	44
I.D. NUMBER MISSING	1	0	0	1
TOTAL	33	32	18	83

TABLE A-3

AMERICAN HOSPITAL ASSOCIATION

BED SIZE DATA

UNITED STATES HOSPITALS

Hospital Size Beds	Number of Hospitals	Percent
50 - 99	1,720	31.78
100 - 199	1,552	28.68
200 - 299	786	14.53
300 - 399	441	8.15
400 - 499	298	5.51
500+	614	11.35
Total	5,411	100.00%

TABLE A-4

AMERICAN HOSPITAL ASSOCIATION

BED SIZE DATA

UNITED STATES HOSPITALS

Hospital Size Beds	Number of Hospitals	Percent
50 - 99	1,720	31.78
100 - 299	2,338	43.21
300+	1,353	25.01
Total	5,411	100.00%

*Source: Hospital Statistics, 1976 Edition, American Hospital Association

TABLE A-5

HOSPITAL ADMINISTRATOR RESPONDENTS

Hospital Size Beds	Observed[1]		Expected[2]	
	N	%	N	%
50 - 99	240	33.38	228	31.78
100 - 199	212	29.49	206	28.68
200 - 299	109	15.16	104	14.53
300 - 399	53	7.37	59	8.15
400 - 499	43	5.98	40	5.51
500+	62	8.62	82	11.35
Total	719	100.00	719	100.00

$X^2 = 6.7600$

[1] 33 responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Three responses omitted bed size data.

[2] Based on total N of respondents and Table A-3.

Note: The X^2 value of Table A-5 indicates that the sample does not significantly differ from the population in the distribution of respondents.

TABLE A-6

HOSPITAL ADMINISTRATOR RESPONDENTS

Hospital Size Beds	Observed[1]		Expected[2]	
	N	%	N	%
50 - 99	240	33.38	228	31.78
100 - 299	321	44.65	310	43.21
300+	158	21.97	181	25.01
Total	719	100.00	719	100.00

$X^2 = 3.9446$

[1] 33 responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Three responses omitted bed size data.

[2] Based on total N of respondents and Table A-4.

Note: The X^2 value of Table A-6 indicates that the sample does not significantly differ from the population in the distribution of respondents.

TABLE A-7

QUESTIONNAIRE FORM 1

MANAGERIAL ACTIVITIES FORM

Hospital Size Beds	Observed[1]		Expected[2]	
	N	%	N	%
50 - 99	101	34.71	92	31.78
100 - 299	122	41.92	126	43.21
300 +	68	23.37	73	25.01
Total	291	100.00	291	100.00

$X^2 = 1.3499$

[1] 15 Responses were received from instititions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here.

[2] Based on total N of respondents to this form and Table A-4.

Note: The X^2 value of Table A-7 indicates that the sample does not significantly differ from the population in the distribution of respondents.

TABLE A-8

QUESTIONNAIRE FORM 2

MANAGERIAL ROLE DESCRIPTIONS FORM

Hospital Size Beds	Observed[1]		Expected[2]	
	N	%	N	%
50 - 99	80	30.30	84	31.78
100 - 299	131	49.62	114	43.21
300 +	53	20.08	66	25.01
Total	264	100.00	264	100.00

$X^2 = 5.2862$

[1] 10 responses were received from institutions reporting bed sizes less than 50; since such instititions were supposedly not included in the sample, they are omitted here.

[2] Based on total N of respondents to this form and Table A-4.

Note: The X^2 value of Table A-8 indicates that the sample does not significantly differ from the population in the distribution of respondents.

TABLE A-9

QUESTIONNAIRE FORM 3

TASK ACTIVITIES FORM

Hospital Size	Observed[1]		Expected[2]	
Beds	N	%	N	%
50 - 99	59	35.98	52	31.78
100 - 299	68	41.46	71	43.21
300 +	37	22.56	41	25.01
Total	164	100.00	164	100.00

$X^2 = 1.4593$

[1] 8 responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here.

[2] Based on total N of respondents to this form and Table A-4.

Note: The X^2 value of Table A-9 indicates that the sample does not significantly differ from the population in the distribution of respondents.

TABLE A-10

QUESTIONNAIRE FORM 1
MANAGERIAL ACTIVITIES FORM
AVERAGE BED SIZE IN HOSPITALS

Hospital Size	AHA Data	Sample Data			$t = \frac{\overline{X} - \mu}{s/\sqrt{n}}$
Beds		N	Mean	S.D.	
50- 99	71.86	101	71.75	14.010	-.079
100-299	175.98	122	174.78	51.188	-.259
300+	646.22	68	646.00	422.897	-.004
All respondents[1]		291	249.13	304.459	

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[1] Fifteen responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here.

TABLE A-11

QUESTIONNAIRE FORM 1
MANAGERIAL ACTIVITIES FORM
AVERAGE DAILY CENSUS IN HOSPITALS

Hospital Size	AHA Data	Sample Data			$t = \frac{\overline{X} - \mu}{s/\sqrt{n}}$
Beds		N	Mean	S.D.	
50- 99	46.68	97	49.53	14.43	1.945
100-299	130.09	119	132.05	49.06	.436
300+	524.04	65	546.57	429.24	.423
All respondents[1]		281	199.45	284.41	

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[1] Fifteen responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Ten responses omitted census data.

TABLE A-12

QUESTIONNAIRE FORM 1
MANAGERIAL ACTIVITIES FORM
AVERAGE PERSONNEL IN HOSPITALS

Hospital Size Beds	AHA Data	Sample Data N	 Mean	 S.D.	$t = \frac{\bar{X} - \mu}{s/\sqrt{n}}$
50 - 99	139.30	97	146.28	62.95	1.092
100-299	404.02	116	386.30	186.39	-1.024
300+	1282.47	60	1197.43	578.05	-1.140
All respondents[1]		273	479.29	495.55	

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[1] Fifteen responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Eighteen responses omitted total personnel data.

TABLE A-13

QUESTIONNAIRE FORM 2
MANAGERIAL ROLE DESCRIPTIONS FORM
AVERAGE BED SIZE IN HOSPITALS

Hospital Size	AHA Data	Sample Data			$t = \frac{\overline{X} - \mu}{s/\sqrt{n}}$
Beds		N	Mean	S.D.	
50- 99	71.86	80	72.27	14.84	.247
100-300	175.98	131	168.56	58.98	-1.440
300+	646.22	53	491.45	203.71	-5.531**
All respondents[1]		264	204.20	180.40	

**Difference is significant at .01 level.

[1] Ten responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. One response omitted bed size data.

TABLE A-14

QUESTIONNAIRE FORM 2
MANAGERIAL ROLE DESCRIPTIONS FORM
AVERAGE DAILY CENSUS IN HOSPITALS

Hospital Size	AHA Data	Sample Data			$t = \frac{\overline{X} - \mu}{s/\sqrt{n}}$
Beds		N	Mean	S.D.	
50- 99	46.68	79	47.51	15.41	.479
100-299	130.09	123	124.67	53.61	-1.121
300+	524.04	51	394.67	177.35	-5.209**
All respondents[1]		253	155.00	152.98	

**Difference is significant at .01 level.

[1] Ten responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Twelve responses omitted census data.

TABLE A-15

QUESTIONNAIRE FORM 2
MANAGERIAL ROLE DESCRIPTIONS FORM
AVERAGE PERSONNEL IN HOSPITALS

Hospital Size	AHA Data	Sample Data			$t = \frac{\overline{X} - \mu}{s/\sqrt{n}}$
Beds		N	Mean	S.D.	
50- 99	139.30	77	140.90	66.84	.210
100-299	404.02	119	385.84	199.22	-.995
300+	1282.47	49	1229.33	673.87	-.552
All respondents[1]		245	477.56	513.11	

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[1] Ten responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Twenty responses omitted total personnel data.

TABLE A-16

QUESTIONNAIRE FORM 3
TASK ACTIVITIES FORM
AVERAGE BED SIZE IN HOSPITALS

Hospital Size	AHA Data	Sample Data			$t = \frac{\overline{X} - \mu}{s/\sqrt{n}}$
Beds		N	Mean	S.D.	
50- 99	71.86	59	71.63	14.58	-.121
100-299	175.98	68	174.38	57.81	-.228
300+	646.22	37	520.51	258.60	-2.957**
All respondents[1]		164	215.51	213.39	

**Difference is significant at .01 level.

[1] Eight responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample they are omitted here. Two responses omitted bed size data.

TABLE A-17

QUESTIONNAIRE FORM 3
TASK ACTIVITIES FORM
AVERAGE DAILY CENSUS IN HOSPITALS

Hospital Size	AHA Data	Sample Data			$t = \frac{\overline{X} - \mu}{s/\sqrt{n}}$
Beds		N	Mean	S.D.	
50- 99	46.68	57	49.91	14.142	1.724
100-299	130.09	66	128.30	54.461	-.267
300+	524.04	34	432.44	269.920	-1.979
All respondents[1]		157	165.71	194.209	

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[1] Eight responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Nine responses omitted census data.

TABLE A-18

QUESTIONNAIRE FORM 3
TASK ACTIVITIES FORM
AVERAGE PERSONNEL IN HOSPITALS

Hospital Size	AHA Data		Sample Data		$t = \frac{\bar{X} - \mu}{s/\sqrt{n}}$
Beds		N	Mean	S.D.	
50- 99	139.30	57	132.51	41.77	-1.227
100-299	404.02	66	410.39	236.52	.219
300+	1282.47	35	1098.23	731.20	-1.491
All respondents[1]		158	462.51	519.94	

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[1] Eight responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Eight responses omitted total personnel data.

TABLE A-19

ALL HOSPITAL ADMINISTRATORS
AVERAGE BED SIZE IN HOSPITALS

Hospital Size	AHA Data		Sample Data		$t = \frac{\overline{X} - \mu}{s/\sqrt{n}}$
Beds		N	Mean	S.D.	
50- 99	71.86	240	71.90	14.372	.043
100-299	175.98	321	172.16	55.793	-1.227
300+	646.22	158	564.77	332.466	-3.079**
All respondents[1]		719	224.97	245.81	

**Difference is significant at .01 level.

[1] Thirty-three responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Three responses omitted bed size data.

TABLE A-20

ALL HOSPITAL ADMINISTRATORS
AVERAGE DAILY CENSUS IN HOSPITALS

Hospital Size	AHA Data		Sample Data		$t = \frac{\overline{X} - \mu}{s/\sqrt{n}}$
Beds		N	Mean	S.D.	
50- 99	46.68	233	48.94	14.68	2.350*
100-299	130.09	308	128.30	52.02	-.604
300+	524.04	150	469.05	332.64	-2.025*
All respondents[1]		691	175.51	224.29	

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*Difference is significant at .05 level.

[1] Thirty-three responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Thirty-one responses omitted census data.

TABLE A-21

ALL HOSPITAL ADMINISTRATORS
AVERAGE PERSONNEL IN HOSPITALS

Hospital Size Beds	AHA Data	Sample Data N	 Mean	 S.D.	$t = \frac{\bar{X} - \mu}{s/\sqrt{n}}$
50- 99	139.30	231	141.09	59.87	.454
100-299	404.02	301	391.40	202.86	-1.079
300+	1282.47	144	1184.17	648.07	-1.820
All respondents[1]		676	474.74	507.00	

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[1] Thirty-three responses were received from institutions reporting bed sizes less than 50; since such institutions were supposedly not included in the sample, they are omitted here. Forty-six responses omitted total personnel data.

TABLE A-22

RESPONDENTS PROVIDING JOB DESCRIPTIONS

Hospital Size Beds	Observed[1]		Expected[2]	
	N	%	N	%
50-99	41	28.87	45	31.78
100-299	71	50.00	61	43.21
300+	30	21.13	36	25.01
Total	142	100.00	142	100.00

$\chi^2 = 2.9949$

---

[1] Five job descriptions were received from institutions reporting bed sizes less than fifty; since such institutions were supposedly not included in the sample, they are omitted here.

[2] Based on total N of respondents providing job descriptions and Table A-4.

TABLE A-23

QUESTIONNAIRES DISTRIBUTED AND USABLE RETURNS RECEIVED BY STATE

	LONG TERM CARE		CLINIC		HMO	
	SENT	USABLE RETURNS	SENT	USABLE RETURNS	SENT	USABLE RETURNS
ILLINOIS	63	20	15	3	7	4
INDIANA	27	10	7	3	-	-
IOWA	10	1	6	2	-	-
MICHIGAN	53	20	6	3	3	1
MINNESOTA	28	14	15	10	7	3
MISSOURI	8	4	6	3	2	1
WISCONSIN	52	21	14	7	3	0
ALABAMA	1	0				
ARIZONA	3	0				
ARKANSAS	-	-				
CALIFORNIA	41	14				
COLORADO	2	0				
CONNECTICUT	15	1				
DELAWARE	-	-				
DIST. OF COLUMBIA	-	-				
FLORIDA	8	4				
GEORGIA	4	3				
HAWAII	3	3				
IDAHO	-	-				
KANSAS	-	-				
KENTUCKY	2	1				
LOUISIANA	1	0				
MAINE	-	-				
MARYLAND	11	5				
MASSACHUSETTS	25	4				
MISSISSIPPI	1	1				
MONTANA	1	1				
NEBRASKA	3	1				
NEVADA	-	-				
NEW HAMPSHIRE	1	0				
NEW JERSEY	7	1				
NEW MEXICO	-	-				
NEW YORK	27	6				
NORTH CAROLINA	2	1				
NORTH DAKOTA	2	1				
OHIO	-	-				
OKLAHOMA	2	0				
OREGON	2	2				
PENNSYLVANIA	5	1				
RHODE ISLAND	1	1				
SOUTH CAROLINA	2	0				
SOUTH DAKOTA	2	0				
TENNESSEE	2	0				
TEXAS	9	1				
UTAH	1	1				
VERMONT	1	0				
VIRGINIA	5	3				
WASHINGTON	5	2				
WEST VIRGINIA	-	-				
WYOMING	-	-				
ALL STATES	439	148	69	31	22	9
PERCENT USABLE		33.8%		44.9%		40.9%

Non-Midwestern states were not sampled for these groups.

438

REFERENCES

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International Directory of the Medical Group Management Association. Denver, Colorado; 1974-75.

Mintzberg, Henry. "A New Look at the Chief Executive's Job," Organizational Dynamics, 1(3), Winter, 1973, pp. 20-30.

APPENDIX B

QUESTIONNAIRE FORMS USED IN THE RESEARCH

Questionnaire Form 1

Managerial Activities: Hospital Administrators............. p. 403

Questionnaire Form 2

Managerial Role Descriptions: Hospital Administrators...... p. 411

Questionnaire Form 3

Managerial Tasks: Hospital Administrators.................. p. 419

Questionnaire Form 4

Managerial Role Descriptions and Managerial Tasks:
Long-Term Care, Clinic, and HMO Administrators........... p. 427

QUESTIONNAIRE FORM 1

SURVEY OF HEALTH SERVICES ADMINISTRATORS

CONFIDENTIAL - All information concerning individuals and organizations will be held confidential. Only researchers engaged in the study will review information and no data pertaining to individuals or organizations will be discussed or released to other persons or used for other purposes.

No. ____________________
For Coding Purposes Only

Circle or check all answers when appropriate. Please print all other responses.

1. Please identify your hospital organization's management. (Please circle only one.)
   - 01. For profit
   - 02. Governmental - federal
   - 03. Governmental - non-federal (state, county, etc.)
   - 04. Non-governmental, not-for-profit (church-related, etc.)
   - 05. Non-governmental, not-for-profit (non-church-related)

2. We would like to have you identify the number of positions in your hospital organization with the following titles or their equivalent. Also, how many of each type report directly to you? (Please place the number in the indicated spaces.)

	NUMBER	NUMBER REPORTING DIRECTLY TO YOU
01. Governing Board	______	
02. Associate Administrator	______	______
03. Assistant Administrator	______	______
04. Department Heads	______	______
05. Affiliated Medical/Dental Staff ..	______	______
06. Other (specify) _______________ ...	______	______
07. Total Hospital Employees (full-time equivalents)	______	

3. Are you a voting member of the Board of Trustees?
   - 01. Yes
   - 02. No

4. How many patient beds are in your hospital? ______

5. What was the average daily census for 1975 in your hospital? ______

6. What is the approximate average geographic radius of coverage of your hospital's emergency room? ______ miles

7. Within that area of coverage (question 6), how many other hospitals provide emergency medical services? ______

8. How many years have you been the administrator (chief executive officer) of your current hospital? ______

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9. Indicate the degree of influence the following have had on the development of the new patient care programs at your hospital during the last three years. In the last column place a check mark (√) to show which will have greater influence in the future.

	Present Influence				√if greater in the future
	Major	Some	Little	None	
Board......................	____	____	____	____	____
Medical Staff..............	____	____	____	____	____
Administrative Staff........	____	____	____	____	____
Department Heads............	____	____	____	____	____
Patients....................	____	____	____	____	____
State Hospital Association..	____	____	____	____	____
J.C.A.H.....................	____	____	____	____	____
A.H.A.......................	____	____	____	____	____
Blue Cross/Blue Shield......	____	____	____	____	____
Federal Government..........	____	____	____	____	____
State/Local Government......	____	____	____	____	____
Community Interest Groups...	____	____	____	____	____
Health Planning Agencies....	____	____	____	____	____
Competing Hospitals.........	____	____	____	____	____

10a. Is there a job description or position guide for your job? ____ Yes ___ No

If you answered YES, we would appreciate a copy of it. If you answered NO, please go on to 10b.

b. What do you think is your role(s) [function(s)] as a hospital administrator?

____

____

____

____

____

____

____

11. Do you believe your role(s) [function(s)] will change in the future? __Yes __No

If yes, please explain how the role(s) will change. ______________________________

____

____

____

12. Rank each of the following methods from most to least important in terms of how you can influence your hospital's policy (1 is most important, 2 is next important, ...6 is least important.)

____ Vote on Board of Trustees
____ Preparation of specific studies for Board
____ Personal and informal contacts with Board members
____ References to literature, legislation, etc.
____ Persuade physicians to recommend policies
____ Other (please specify) ______________________________________

____

13. What was the year of your birth? ______

14. Please list your post high school education.

University (College)	Degree Received	Major

15. Beginning with your present title, please list the titles of all administrative positions you have held in health care organizations and the length of time you held each position. In the indicated column, place a check mark (✓) if it was a chief executive position.

Title	Years	✓if a chief executive position
(Current)		

16. If you attended any professional development, education, or training programs in 1975, who sponsored the program? (Please circle as many as are appropriate.) If you did not attend any programs, please circle number 11 below.

01. Hospital-sponsored education/training program
02. State Hospital Association
03. American Hospital Association
04. American College of Hospital Administrators
05. College/University Extension Service
06. College/University degree course
07. American Management Association
08. State government sponsored
09. Hospital Financial Management Association
10. Other (specify) ____________
11. Did not attend in 1975.

17. While in your present position have you felt the need for additional education for any of the following reasons? (Please check appropriate yes or no space for each item.)

YES NO

___ ___ 01. My profession expects it.
___ ___ 02. Board expects it.
___ ___ 03. I need more education/training to meet changing demands of my present position.
___ ___ 04. I need more education/training to prepare myself for career advancement.
___ ___ 05. I would like to study in some related field.
___ ___ 06. I would like some culture-broadening education.
___ ___ 07. Other (specify) ________________________________

18. If you were to pursue continuing education, would it be essential that the course earn academic credit for you? (Circle one.)

01. Yes
02. No

19. TEN MANAGERIAL ACTIVITIES ARE LISTED ON PAGE 5. PLEASE READ THE DESCRIPTION OF THESE ACTIVITIES AND ANSWER THE FOLLOWING QUESTIONS.

Question 19.1: How much of your time does each of these activities require?

Instructions: Place the letter of the least time consuming activity in box I below and the most time consuming in box V. Place the next two least time consuming in box II and do the same for the next two most time consuming in box IV. The rest of the four items are in box III. Please use the designated letters, A through J.

	____	____ ____ ____	____	
I Least Time Consuming	II Below Average	III Average	IV Above Average	V Most Time Consuming

Question 19.2: How important is each of these activities in attaining your hospital's goals?

Instructions: Place the letter of the least important activity in box I below and the letter of the most important in box V. Place the next two of least importance in box II and do the same for the next two most important in box IV. Then place the letters of the remaining activities in box III.

	____	____ ____ ____	____	
I Least Important	II Below Average Importance	III Average Importance	IV Above Average Importance	V Most Important

Question 19.3: What do you anticipate will be the importance of each of these activities in the future (three to five years)?

Instructions: Place the letter of the anticipated least important activity in box I below, and the letter of the anticipated most important in box V. Place the next two of least importance in box II and do the same for the next two most important in box IV. Then place the letters of the remaining activities in box III.

	____	____ ____ ____	____	
I Anticipated Least Important	II Below Average Anticipated Importance	III Average Anticipated Importance	IV Above Average Anticipated Importance	V Anticipated Most Important

MANAGERIAL ACTIVITIES

A. Determination of Goals and Objectives -- (This consists primarily of activities dealing with policy making committees and boards, where the subject matter concerns overall hospital policy.)

B. Financial Management -- (This classification relates to the internal financial affairs of the hospital. It includes budgeting, both development and review.)

C. Personnel Management -- (This category relates to the selection, evaluation, and motivation of employees. It includes wage and salary administration/determination.)

D. Coordinating Department Operations -- (This category includes activities dealing with the internal functioning of any hospital department. Routine meetings with department heads would be one example, unless the subject matter clearly belonged in a different classification.)

E. Program Review & Evaluation -- (This relates to the general functioning of the clinical services. It is concerned primarily with the evaluation and review of various projects and programs.)

F. Planning - Facility and Program -- (This classification refers primarily to the activities involved in remodeling projects, space problems, and new facility construction as well as new services and programs. It does not include financing, personnel, etc.)

G. Public and Community Activities -- (This classification concerns activities related to the development and maintenance of interaction with other health service-providing institutions/agencies, including shared service arrangements with other providers, coordination, etc.)

H. Health Industry Activities -- (This classification refers to activities that are external to the hospital. It includes participation in hospital associations, professional societies, etc.)

I. Government Related Activities -- (This activity is concerned with the legal problems of the hospital plus the activities in dealing with local, state, or federal agencies.)

J. Educational Development -- (This category includes all teaching and lecturing responsibilities, plus personal continuing education.)

20. Please answer the three questions about the patient care programs listed in the right-hand column. Please use capital letters to designate the programs in answer to the questions.

1. Which of the patient services listed to the right are provided by the hospital at present? (Use capital letters.)

   ___ ___ ___ ___ ___

   ___ ___ ___ ___ ___

2. Which of the patient services listed do you plan to add in the next three years?

   ___ ___ ___ ___ ___

   ___ ___ ___ ___ ___

3. Which of these patient services have been assigned to other hospitals or agencies in the community by the planning agency?

   ___ ___ ___ ___ ___

   ___ ___ ___ ___ ___

A. Rehabilitation Unit

B. Organized Outpatient Department

C. Home Care Department

D. Retirement Center

E. Ambulatory Self-Care Unit (inpatient)

F. Extended Care or Long-Term Nursing Unit

G. Alcohol Abuse Program

H. Surgicenter

I. Community Health Training Program

J. Group Practice Clinic

21. For each of the following management programs, please indicate which your hospital has had for at least three or more years, which has been added during the last three years (since 1973), and which are planned for the next three years. Consider only formal programs.

Part I:	Have had three or more years	Added in last three years	Plan to add in next three years	Do not plan to add
•Personnel department	( )	( )	( )	( )
•Purchasing department	( )	( )	( )	( )
•Annual personnel budgets	( )	( )	( )	( )
•Annual expense budgets	( )	( )	( )	( )
•Employee recognition program	( )	( )	( )	( )
•In-service education program	( )	( )	( )	( )
•Policy and procedure manual	( )	( )	( )	( )
•Cash flow budget	( )	( )	( )	( )
Part II:				
•Community relations program	( )	( )	( )	( )
•Trustee education program	( )	( )	( )	( )
•Labor relations specialist	( )	( )	( )	( )
•Program budgeting	( )	( )	( )	( )
•Cost/benefit analyses	( )	( )	( )	( )
•Employee health service	( )	( )	( )	( )
•Service area market studies	( )	( )	( )	( )
•Long-range planning (programs)	( )	( )	( )	( )
•Long-range planning (facilities)	( )	( )	( )	( )
•Capital expansion program	( )	( )	( )	( )
•Job evaluation program	( )	( )	( )	( )
Part III:				
•Management by objectives program	( )	( )	( )	( )
•Reorganization studies	( )	( )	( )	( )
•Systems engineering program	( )	( )	( )	( )
•Cost containment programs	( )	( )	( )	( )
•Management appraisal program	( )	( )	( )	( )
•Shared service programs	( )	( )	( )	( )
•Outside service contracts	( )	( )	( )	( )
•Professional standards review program	( )	( )	( )	( )
•Management information systems	( )	( )	( )	( )
•Computerized manpower planning	( )	( )	( )	( )
•Health maintenance organization	( )	( )	( )	( )
•Problem oriented medical records	( )	( )	( )	( )

22. From your point of view as an administrator, for each of the following kinds of goals, indicate the thermometer-scale number that expresses its importance in your hospital.

Planning for expansion of hospital patient care programs ___

Planning for expansion of hospital facilities ___

High quality patient care ___

Coordination with community health care services ___

Recruitment and retention of professional staff ___

Development of harmonious interpersonal relationships among staff ___

Cost containment ___

Good community relationships ___

Good relationships with governmental agencies ___

Good relationships with third party payers ___

Teaching ___

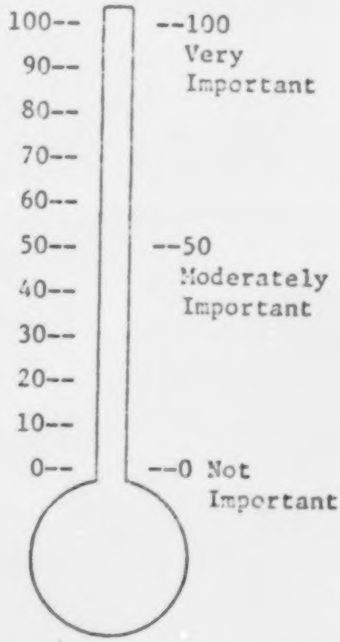
Research ___

Shared services with other hospitals ___

Planned improvement of administrative services ___

Other (specify) ______________________________ ___

Other (specify) ______________________________ ___



23. Based upon your experiences, which skills and abilities should be developed by those in training to become hospital administrators? (We would also like your insights and your thoughts regarding skills and abilities needed in the future by hospital administrators.)

We would appreciate any comments you may have.

Thank you!

QUESTIONNAIRE FORM 2

SURVEY OF HEALTH SERVICES ADMINISTRATORS

CONFIDENTIAL - All information concerning individuals and organizations will be held confidential. Only researchers engaged in the study will review information and no data pertaining to individuals or organizations will be discussed or released to other persons or used for other purposes.

No. ____________________
For Coding Purposes Only

Circle or check all answers when appropriate. Please print all other responses.

1. Please identify your hospital organization's management. (Please circle only one.)
   - 01. For profit
   - 02. Governmental - federal
   - 03. Governmental - non-federal (state, county, etc.)
   - 04. Non-governmental, not-for-profit (church-related, etc.)
   - 05. Non-governmental, not-for-profit (non-church-related)

2. We would like to have you identify the number of positions in your hospital organization with the following titles or their equivalent. Also, how many of each type report directly to you? (Please place the number in the indicated spaces.)

	NUMBER	NUMBER REPORTING DIRECTLY TO YOU
01. Governing Board	______	
02. Associate Administrator	______	______
03. Assistant Administrator	______	______
04. Department Heads	______	______
05. Affiliated Medical/Dental Staff ..	______	______
06. Other (specify) ______________ ...	______	______
07. Total Hospital Employees (full-time equivalents)	______	

3. Are you a voting member of the Board of Trustees?
   - 01. Yes
   - 02. No

4. How many patient beds are in your hospital? ______

5. What was the average daily census for 1975 in your hospital? ______

6. What is the approximate average geographic radius of coverage of your hospital's emergency room? ______ miles

7. Within that area of coverage (question 6), how many other hospitals provide emergency medical services? ______

8. How many years have you been the administrator (chief executive officer) of your current hospital? ______

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9. Indicate the degree of influence the following have had on the development of the new patient care programs at your hospital during the last three years. In the last column place a check mark (✓) to show which will have greater influence in the future.

	Present Influence				✓if greater in the future
	Major	Some	Little	None	
Board........................	____	____	____	____	____
Medical Staff................	____	____	____	____	____
Administrative Staff........	____	____	____	____	____
Department Heads............	____	____	____	____	____
Patients.....................	____	____	____	____	____
State Hospital Association..	____	____	____	____	____
J.C.A.H.....................	____	____	____	____	____
A.H.A.......................	____	____	____	____	____
Blue Cross/Blue Shield......	____	____	____	____	____
Federal Government..........	____	____	____	____	____
State/Local Government......	____	____	____	____	____
Community Interest Groups...	____	____	____	____	____
Health Planning Agencies....	____	____	____	____	____
Competing Hospitals.........	____	____	____	____	____

10a. Is there a job description or position guide for your job? ____ Yes ___ No

If you answered YES, we would appreciate a copy of it. If you answered NO, please go on to 10b.

b. What do you think is your role(s) [function(s)] as a hospital administrator?

____

____

____

____

____

____

____

11. Do you believe your role(s) [function(s)] will change in the future? __Yes __No

If yes, please explain how the role(s) will change. ______________________________

____

____

____

12. Rank each of the following methods from most to least important in terms of how you can influence your hospital's policy (1 is most important, 2 is next important, ...6 is least important.)

____ Vote on Board of Trustees
____ Preparation of specific studies for Board
____ Personal and informal contacts with Board members
____ References to literature, legislation, etc.
____ Persuade physicians to recommend policies
____ Other (please specify) ______________________________________

____

13. What was the year of your birth? ______

14. Please list your post high school education.

University (College)	Degree Received	Major

15. Beginning with your present title, please list the titles of all administrative positions you have held in health care organizations and the length of time you held each position. In the indicated column, place a check mark (✓) if it was a chief executive position.

Title	Years	✓if a chief executive position
(Current)		

16. If you attended any professional development, education, or training programs in 1975, who sponsored the program? (Please circle as many as are appropriate.) If you did not attend any programs, please circle number 11 below.

01. Hospital-sponsored education/training program
02. State Hospital Association
03. American Hospital Association
04. American College of Hospital Administrators
05. College/University Extension Service
06. College/University degree course
07. American Management Association
08. State government sponsored
09. Hospital Financial Management Association
10. Other (specify) ____________
11. Did not attend in 1975.

17. While in your present position have you felt the need for additional education for any of the following reasons? (Please check appropriate yes or no space for each item.)

YES	NO	
___	___	01. My profession expects it.
___	___	02. Board expects it.
___	___	03. I need more education/training to meet changing demands of my present position.
___	___	04. I need more education/training to prepare myself for career advancement.
___	___	05. I would like to study in some related field.
___	___	06. I would like some culture-broadening education.
___	___	07. Other (specify) ______________________________

18. If you were to pursue continuing education, would it be essential that the course earn academic credit for you? (Circle one.)

01. Yes
02. No

19. TEN MANAGERIAL ROLE DESCRIPTIONS ARE LISTED ON PAGE 5. PLEASE READ THESE ROLE DESCRIPTIONS AND ANSWER THE FOLLOWING QUESTIONS.

Question 19.1: How much of your time does each of these roles require?

Instructions: Place the letter of the least time consuming role in box I below and the most time consuming in box V. Place the next two least time consuming in box II and do the same for the next two most time consuming in box IV. The rest of the four items are in box III. Please use the designated letters, A through J.

	____	____ ____ ____	____	
I Least Time Consuming	II Below Average	III Average	IV Above Average	V Most Time Consuming

Question 19.2: How important is each of these roles in attaining your hospital's goals?

Instructions: Place the letter of the least important role in box I below and the letter of the most important in box V. Place the next two of least importance in box II and do the same for the next two most important in box IV. Then place the letters of the remaining roles in box III.

	____	____ ____ ____	____	
I Least Important	II Below Average Importance	III Average Importance	IV Above Average Importance	V Most Important

Question 19.3: What do you anticipate will be the importance of each of these roles in the future (three to five years)?

Instructions: Place the letter of the anticipated least important role in box I below, and the letter of the anticipated most important in box V. Place the next two of least importance in box II and do the same for the next two most important in box IV. Then place the letters of the remaining roles in box III.

	____	____ ____ ____	____	
I Anticipated Least Important	II Below Average Anticipated Importance	III Average Anticipated Importance	IV Above Average Anticipated Importance	V Anticipated Most Important

MANAGERIAL ROLE DESCRIPTIONS

A. The figurehead role: the chief executive is a symbol required by the status of his office to carry out a variety of social, legal, and ceremonial duties in which he represents the hospital.

B. The leader role: the chief executive has interpersonal relationships with his subordinates; as he hires, trains, and motivates them, he must essentially bring their needs in accord with those of the organization.

C. The liaison role: the chief executive has interpersonal relationships with people outside of his own organization and spends a considerable amount of time developing a network of high-status contacts in which information and favors are traded for mutual benefit and through which the chief executive exerts community leadership.

D. The monitor role: the chief executive continually seeks and receives information about his organization in order to understand changing situations and his organization's environment.

E. The disseminator role: the chief executive shares some of the environmental information with his subordinates.

F. The spokesman role: the chief executive informs outsiders about the progress, problems, and activities of his hospital.

G. The entrepreneur role: the chief executive takes the responsibility for bringing about changes in his organization, looking for problems and opportunities, and then initiating projects to deal with them.

H. The disturbance-handler role: the chief executive takes charge when his organization faces a major disturbance or crisis and deals with the resulting problems.

I. The resource allocator role: the chief executive decides who will get what in his organization; he establishes priorities, designs his organization, and authorizes all important decisions.

J. The negotiator role: the chief executive takes charge whenever his organization must enter into crucial negotiations with other parties; his presence is required because he has the information and the authority to make the decisions that difficult negotiations require.

20. Please answer the three questions about the patient care programs listed in the right-hand column. Please use capital letters to designate the programs in answer to the questions.

    1. Which of the patient services listed to the right are provided by the hospital at present? (Use capital letters.)

       ___ ___ ___ ___ ___

       ___ ___ ___ ___ ___

    2. Which of the patient services listed do you plan to add in the next three years?

       ___ ___ ___ ___ ___

       ___ ___ ___ ___ ___

    3. Which of these patient services have been assigned to other hospitals or agencies in the community by the planning agency?

       ___ ___ ___ ___ ___

       ___ ___ ___ ___ ___

A. Rehabilitation Unit

B. Organized Outpatient Department

C. Home Care Department

D. Retirement Center

E. Ambulatory Self-Care Unit (inpatient)

F. Extended Care or Long-Term Nursing Unit

G. Alcohol Abuse Program

H. Surgicenter

I. Community Health Training Program

J. Group Practice Clinic

21. For each of the following management programs, please indicate which your hospital has had for at least three or more years, which has been added during the last three years (since 1973), and which are planned for the next three years. Consider only formal programs.

Part I:	Have had three or more years	Added in last three years	Plan to add in next three years	Do not plan to add
•Personnel department	( )	( )	( )	( )
•Purchasing department	( )	( )	( )	( )
•Annual personnel budgets	( )	( )	( )	( )
•Annual expense budgets	( )	( )	( )	( )
•Employee recognition program	( )	( )	( )	( )
•In-service education program	( )	( )	( )	( )
•Policy and procedure manual	( )	( )	( )	( )
•Cash flow budget	( )	( )	( )	( )
Part II:				
•Community relations program	( )	( )	( )	( )
•Trustee education program	( )	( )	( )	( )
•Labor relations specialist	( )	( )	( )	( )
•Program budgeting	( )	( )	( )	( )
•Cost/benefit analyses	( )	( )	( )	( )
•Employee health service	( )	( )	( )	( )
•Service area market studies	( )	( )	( )	( )
•Long-range planning (programs)	( )	( )	( )	( )
•Long-range planning (facilities)	( )	( )	( )	( )
•Capital expansion program	( )	( )	( )	( )
•Job evaluation program	( )	( )	( )	( )
Part III:				
•Management by objectives program	( )	( )	( )	( )
•Reorganization studies	( )	( )	( )	( )
•Systems engineering program	( )	( )	( )	( )
•Cost containment programs	( )	( )	( )	( )
•Management appraisal program	( )	( )	( )	( )
•Shared service programs	( )	( )	( )	( )
•Outside service contracts	( )	( )	( )	( )
•Professional standards review program	( )	( )	( )	( )
•Management information systems	( )	( )	( )	( )
•Computerized manpower planning	( )	( )	( )	( )
•Health maintenance organization	( )	( )	( )	( )
•Problem oriented medical records	( )	( )	( )	( )

22. From your point of view as an administrator, for each of the following kinds of goals, indicate the thermometer-scale number that expresses its importance in your hospital.

Planning for expansion of hospital patient care programs ___

Planning for expansion of hospital facilities ___

High quality patient care ___

Coordination with community health care services ___

Recruitment and retention of professional staff ___

Development of harmonious interpersonal relationships among staff ___

Cost containment ___

Good community relationships ___

Good relationships with governmental agencies ___

Good relationships with third party payers ___

Teaching ___

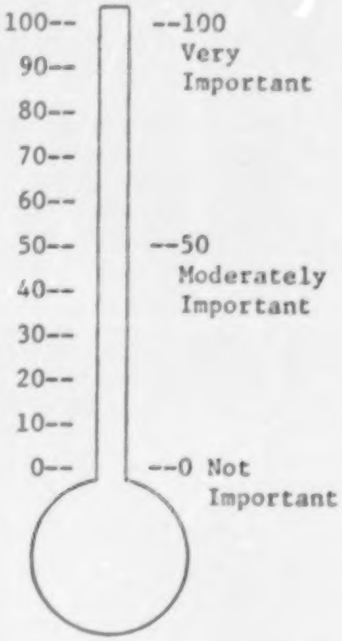
Research ___

Shared services with other hospitals ___

Planned improvement of administrative services ___

Other (specify) ______________________________ ___

Other (specify) ______________________________ ___



23. Based upon your experiences, which skills and abilities should be developed by those in training to become hospital administrators? (We would also like your insights and your thoughts regarding skills and abilities needed in the future by hospital administrators.)

We would appreciate any comments you may have.

Thank you!

QUESTIONNAIRE FORM 3

SURVEY OF HEALTH SERVICES ADMINISTRATORS

CONFIDENTIAL - All information concerning individuals and organizations will be held confidential. Only researchers engaged in the study will review information and no data pertaining to individuals or organizations will be discussed or released to other persons or used for other purposes.

No. ____________________
For Coding Purposes Only

Circle or check all answers when appropriate. Please print all other responses.

1. Please identify your hospital organization's management. (Please circle only one.)
   01. For profit
   02. Governmental - federal
   03. Governmental - non-federal (state, county, etc.)
   04. Non-governmental, not-for-profit (church-related, etc.)
   05. Non-governmental, not-for-profit (non-church-related)

2. We would like to have you identify the number of positions in your hospital organization with the following titles or their equivalent. Also, how many of each type report directly to you? (Please place the number in the indicated spaces.)

	NUMBER	NUMBER REPORTING DIRECTLY TO YOU
01. Governing Board	______	
02. Associate Administrator	______	______
03. Assistant Administrator	______	______
04. Department Heads	______	______
05. Affiliated Medical/Dental Staff ..	______	______
06. Other (specify) _____________ ...	______	______
07. Total Hospital Employees (full-time equivalents)	______	

3. Are you a voting member of the Board of Trustees?
   01. Yes
   02. No

4. How many patient beds are in your hospital? ______

5. What was the average daily census for 1975 in your hospital? ______

6. What is the approximate average geographic radius of coverage of your hospital's emergency room? ______ miles

7. Within that area of coverage (question 6), how many other hospitals provide emergency medical services? ______

8. How many years have you been the administrator (chief executive officer) of your current hospital? ______

O.M.B. #68-S74074
Approval expires 083176

QUESTIONNAIRE FORM 3

9. Indicate the degree of influence the following have had on the development of the new patient care programs at your hospital during the last three years. In the last column place a check mark (✓) to show which will have greater influence in the future.

	Present Influence				✓if greater in the future
	Major	Some	Little	None	
Board........................					
Medical Staff................					
Administrative Staff.........					
Department Heads.............					
Patients.....................					
State Hospital Association..					
J.C.A.H......................					
A.H.A........................					
Blue Cross/Blue Shield.......					
Federal Government...........					
State/Local Government.......					
Community Interest Groups....					
Health Planning Agencies.....					
Competing Hospitals..........					

10a. Is there a job description or position guide for your job? ____ Yes ___ No

If you answered YES, we would appreciate a copy of it. If you answered NO, please go on to 10b.

b. What do you think is your role(s) [function(s)] as a hospital administrator?

11. Do you believe your role(s) [function(s)] will change in the future? __Yes __No

If yes, please explain how the role(s) will change. ____________________

12. Rank each of the following methods from most to least important in terms of how you can influence your hospital's policy (1 is most important, 2 is next important, ...6 is least important.)

____ Vote on Board of Trustees
____ Preparation of specific studies for Board
____ Personal and informal contacts with Board members
____ References to literature, legislation, etc.
____ Persuade physicians to recommend policies
____ Other (please specify) ____________________

13. What was the year of your birth? _____

14. Please list your post high school education.

University (College)	Degree Received	Major

15. Beginning with your present title, please list the titles of all administrative positions you have held in health care organizations and the length of time you held each position. In the indicated column, place a check mark (✓) if it was a chief executive position.

Title	Years	✓if a chief executive position
(Current)		

16. If you attended any professional development, education, or training programs in 1975, who sponsored the program? (Please circle as many as are appropriate.) If you did not attend any programs, please circle number 11 below.

01. Hospital-sponsored education/training program
02. State Hospital Association
03. American Hospital Association
04. American College of Hospital Administrators
05. College/University Extension Service
06. College/University degree course
07. American Management Association
08. State government sponsored
09. Hospital Financial Management Association
10. Other (specify) ____________
11. Did not attend in 1975.

17. While in your present position have you felt the need for additional education for any of the following reasons? (Please check appropriate yes or no space for each item.)

YES	NO	
___	___	01. My profession expects it.
___	___	02. Board expects it.
___	___	03. I need more education/training to meet changing demands of my present position.
___	___	04. I need more education/training to prepare myself for career advancement.
___	___	05. I would like to study in some related field.
___	___	06. I would like some culture-broadening education.
___	___	07. Other (specify) ____________________________

18. If you were to pursue continuing education, would it be essential that the course earn academic credit for you? (Circle one.)
01. Yes
02. No

19. To give us information about how duties are divided among your-elf and others, please place a check mark (✓) in the appropriate column. (Check only one answer per line.)

Column headings have the following definitions:

1. This activity is a primary duty of mine and is usually performed directly by me.
2. This activity is a responsibility of mine but is usually accomplished indirectly by my delegating it to others.
3. This activity is not a direct responsibility of mine but is performed by other individuals in the hospital.
4. This activity is not performed by hospital personnel.

	1 Performed directly	2 Accomplished indirectly	3 Performed by others	4 Not Performed
Group I:				
• Appoint administrative personnel	( )	( )	( )	( )
• Appoint department heads	( )	( )	( )	( )
• Approve promotions and transfers of department heads	( )	( )	( )	( )
• Coordinate personnel programs	( )	( )	( )	( )
• Develop personnel recruiting methods	( )	( )	( )	( )
• Direct personnel training programs	( )	( )	( )	( )
• Formulate personnel policies	( )	( )	( )	( )
• Negotiate labor union contracts	( )	( )	( )	( )
• Plan administrative office practices and procedures	( )	( )	( )	( )
• Resolve employee complaints and grievances	( )	( )	( )	( )
• Formulate wage and salary pay plans	( )	( )	( )	( )
• Evaluate training programs	( )	( )	( )	( )
• Evaluate managerial performance	( )	( )	( )	( )
• Plan and determine manpower requirements	( )	( )	( )	( )
• Direct and coordinate activities of nursing services	( )	( )	( )	( )
• Interpret changes in rules and regulations (governmental policies, for example) to hospital employees	( )	( )	( )	( )
Group II:				
• Analyze expenditures	( )	( )	( )	( )
• Negotiate financial agreements (insurance and facilities	( )	( )	( )	( )
• Negotiate reimbursement rates with third party payers	( )	( )	( )	( )
• Prepare operations budget	( )	( )	( )	( )
• Review and revise budget allocations	( )	( )	( )	( )
• Conduct studies of financial performance and recommend changes	( )	( )	( )	( )

	1 Performed directly	2 Accomplished indirectly	3 Performed by others	4 Not Performed
• Approve purchases of expensive equipment	( )	( )	( )	( )
• Prepare administrative reports	( )	( )	( )	( )
• Search the hospital and its environment for more efficient operations	( )	( )	( )	( )
• Recommend to the board the rates to be charged for hospital services	( )	( )	( )	( )
• Solve cash flow problems	( )	( )	( )	( )

Group III:

• Interpret policies, procedures, and hospital regulations	( )	( )	( )	( )
• Investigate patient complaints	( )	( )	( )	( )
• Represent hospital on commissions, agencies, or at hearings	( )	( )	( )	( )
• Establish procedures for preparing and submitting reports	( )	( )	( )	( )
• Communicate health care needs to persons external to the hospital	( )	( )	( )	( )
• Represent the hospital in its relationships to other health agencies	( )	( )	( )	( )
• Assist medical staff with its organizational and medical-administrative problems and responsibilities	( )	( )	( )	( )
• Advise the board of trustees on matters requiring policy formulation	( )	( )	( )	( )
• Develop a long-range planning program for the hospital	( )	( )	( )	( )

Group IV:

• Contract for purchase and delivery of supplies and services	( )	( )	( )	( )
• Coordinate maintenance and repair activities .	( )	( )	( )	( )
• Coordinate hospital safety programs	( )	( )	( )	( )
• Enforce administrative policies and operating procedures	( )	( )	( )	( )
• Formulate patient care policies	( )	( )	( )	( )
• Organize hospital patient care services	( )	( )	( )	( )
• Plan and determine patient care quality standards	( )	( )	( )	( )
• Allocate organizational resources to achieve hospital goals	( )	( )	( )	( )
• Keep informed of legal changes affecting the hospital	( )	( )	( )	( )
• Meet regulatory and accreditation requirements	( )	( )	( )	( )
• Write articles for professional journals of benefit to other administrators	( )	( )	( )	( )

20. Please answer the three questions about the patient care programs listed in the right-hand column. Please use capital letters to designate the programs in answer to the questions.

1. Which of the patient services listed to the right are provided by the hospital at present? (Use capital letters.)

   ___ ___ ___ ___ ___

   ___ ___ ___ ___ ___

2. Which of the patient services listed do you plan to add in the next three years?

   ___ ___ ___ ___ ___

   ___ ___ ___ ___ ___

3. Which of these patient services have been assigned to other hospitals or agencies in the community by the planning agency?

   ___ ___ ___ ___ ___

   ___ ___ ___ ___ ___

A. Rehabilitation Unit

B. Organized Outpatient Department

C. Home Care Department

D. Retirement Center

E. Ambulatory Self-Care Unit (inpatient)

F. Extended Care or Long-Term Nursing Unit

G. Alcohol Abuse Program

H. Surgicenter

I. Community Health Training Program

J. Group Practice Clinic

21. For each of the following management programs, please indicate which your hospital has had for at least three or more years, which has been added during the last three years (since 1973), and which are planned for the next three years. Consider only formal programs.

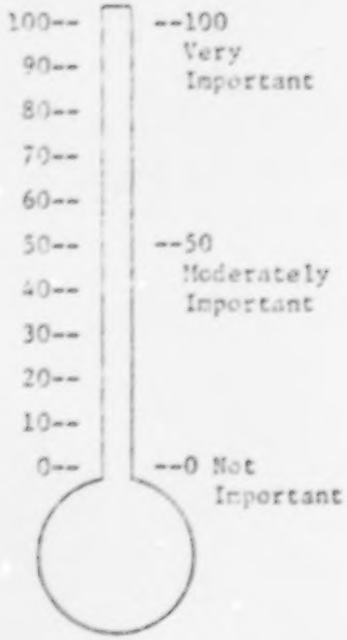
Part I:	Have had three or more years	Added in last three years	Plan to add in next three years	Do not plan to add
•Personnel department	( )	( )	( )	( )
•Purchasing department	( )	( )	( )	( )
•Annual personnel budgets	( )	( )	( )	( )
•Annual expense budgets	( )	( )	( )	( )
•Employee recognition program	( )	( )	( )	( )
•In-service education program	( )	( )	( )	( )
•Policy and procedure manual	( )	( )	( )	( )
•Cash flow budget	( )	( )	( )	( )

Part II:				
•Community relations program	( )	( )	( )	( )
•Trustee education program	( )	( )	( )	( )
•Labor relations specialist	( )	( )	( )	( )
•Program budgeting	( )	( )	( )	( )
•Cost/benefit analyses	( )	( )	( )	( )
•Employee health service	( )	( )	( )	( )
•Service area market studies	( )	( )	( )	( )
•Long-range planning (programs)	( )	( )	( )	( )
•Long-range planning (facilities) ..	( )	( )	( )	( )
•Capital expansion program	( )	( )	( )	( )
•Job evaluation program	( )	( )	( )	( )

Part III:				
•Management by objectives program ..	( )	( )	( )	( )
•Reorganization studies	( )	( )	( )	( )
•Systems engineering program	( )	( )	( )	( )
•Cost containment programs	( )	( )	( )	( )
•Management appraisal program	( )	( )	( )	( )
•Shared service programs	( )	( )	( )	( )
•Outside service contracts	( )	( )	( )	( )
•Professional standards review program	( )	( )	( )	( )
•Management information systems	( )	( )	( )	( )
•Computerized manpower planning	( )	( )	( )	( )
•Health maintenance organization ...	( )	( )	( )	( )
•Problem oriented medical records ..	( )	( )	( )	( )

22. From your point of view as an administrator, for each of the following kinds of goals, indicate the thermometer-scale number that expresses its importance in your hospital.

Planning for expansion of hospital patient care programs ___
Planning for expansion of hospital facilities ___
High quality patient care ___
Coordination with community health care services ___
Recruitment and retention of professional staff ___
Development of harmonious interpersonal relationships among staff ___
Cost containment ___
Good community relationships ___
Good relationships with governmental agencies ___
Good relationships with third party payers ___
Teaching ___
Research ___
Shared services with other hospitals ___
Planned improvement of administrative services ___
Other (specify) ______________________ ___
Other (specify) ______________________ ___



23. Based upon your experiences, which skills and abilities should be developed by those in training to become hospital administrators? (We would also like your insights and your thoughts regarding skills and abilities needed in the future by hospital administrators.)

We would appreciate any comments you may have.

Thank you!

SURVEY OF HEALTH SERVICES ADMINISTRATORS

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No. ______________
For Coding Purposes Only

Circle or check all answers when appropriate. Please print all other responses.

1. Please identify your organization's management. (Please circle only one.)
   - 01. For profit
   - 02. Governmental - federal
   - 03. Governmental - non-federal (state, county, etc.)
   - 04. Non-governmental, not-for-profit (church-related, etc.)
   - 05. Non-governmental, not-for-profit (non-church-related)

2. We would like to have you identify the number of positions in your organization with the following titles or their equivalent. Also, how many of each type report directly to you? (Please place the number in the indicated spaces.)

	NUMBER	NUMBER REPORTING DIRECTLY TO YOU
01. Governing Board	______	
02. Associate Administrator	______	______
03. Assistant Administrator	______	______
04. Department Heads	______	______
05. Affiliated Medical/Dental Staff ..	______	______
06. Other (specify) ______________ ...	______	______
07. Total Employees (full-time equivalents)	______	

3. Are you a voting member of the Board of Trustees?
   - 01. Yes
   - 02. No

4. (For institutional administrators) How many patient beds are in your facility? ___

5. (For institutional administrators) What was the average daily census for 1975 in your facility? ______

6. (For clinic and HMO managers) How many patient visits were made to your facility in 1975? ______

7. Within your geographic area of coverage, how many other organizations provide similar health care services? ______

8. How many years have you been the administrator (chief executive officer) of your current organization? ______

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9. Indicate the degree of influence the following have had on the development of new patient care programs offered by your organization during the last three years. In the last column place a check mark (√) to show which will have greater influence in the future.

	Present Influence				√if greater in the future
	Major	Some	Little	None	
Board	____	____	____	____	____
Medical Staff	____	____	____	____	____
Administrative Staff	____	____	____	____	____
Department Heads	____	____	____	____	____
Patients	____	____	____	____	____
Professional Association	____	____	____	____	____
Blue Cross/Blue Shield	____	____	____	____	____
Federal Government	____	____	____	____	____
State/Local Government	____	____	____	____	____
Community Interest Groups	____	____	____	____	____
Health Planning Agencies	____	____	____	____	____
Competing Organizations	____	____	____	____	____

10a. Is there a job description or position guide for your job? ____ Yes ____ No

If you answered YES, we would appreciate a copy of it.

b. What do you think is your role (function) as a health services administrator?

11. Do you believe your role (function) will change in the future? ____ Yes ____ No

If yes, please explain how the role(s) will change. ____________________

12. Rank each of the following methods from most to least important in terms of how you can influence your organization's policy (1 is most important, 2 is next important, ...6 is least important.)

____ Vote on Board of Trustees
____ Preparation of specific studies for Board
____ Personal and informal contacts with Board members
____ References to literature, legislation, etc.
____ Persuade physicians to recommend policies
____ Other (please specify) ____________________

13. What was the year of your birth? ________

14. Please list your post high school education.

University (College)	Degree Received	Major

15. Beginning with your present title, please list the titles of all administrative positions you have held in health care organizations and the length of time you held each position. In the indicated column, place a check mark (✓) if it was a chief executive position.

Title	Years	✓if a chief executive position
(Current) ________	______	______
________	______	______
________	______	______
________	______	______

16. If you attended any professional development, education, or training programs in 1975, who sponsored the program? (Please circle as many as are appropriate.) If you did not attend any programs, please circle number 11 below.

01. Local organization-sponsored education/training program
02. State Association
03. National Association
04. American Hospital Association
05. College/University Extension Service
06. College/University degree course
07. American Management Association
08. State government sponsored
09. Hospital Financial Management Association
10. Other (specify) ____________
11. Did not attend in 1975.

17. While in your present position have you felt the need for additional education for any of the following reasons? (Please check appropriate yes or no space for each item.)

YES	NO	
___	___	01. My profession expects it.
___	___	02. Board expects it.
___	___	03. I need more education/training to meet changing demands of my present position.
___	___	04. I need more education/training to prepare myself for career advancement.
___	___	05. I would like to study in some related field.
___	___	06. I would like some culture-broadening education.
___	___	07. Required for licensure.
___	___	08. Other (specify) ____________

18. If you were to pursue continuing education, would it be essential that the course earn academic credit for you? (Circle one.)
01. Yes
02. No

19. TEN MANAGERIAL ROLE DESCRIPTIONS ARE LISTED ON PAGE 5. PLEASE READ THESE ROLE DESCRIPTIONS AND ANSWER THE FOLLOWING QUESTIONS.

Question 19.1: How much of your time does each of these roles require?

Instructions: Place the letter of the least time consuming role in box I below and the most time consuming in box V. Place the next two least time consuming in box II and do the same for the next two most time consuming in box IV. The rest of the four items are in box III. Please use the designated letters, A through J.

	____	____ ____ ____	____	
I Least Time Consuming	II Below Average	III Average	IV Above Average	V Most Time Consuming

Question 19.2: How important is each of these roles in attaining your organization's goals?

Instructions: Place the letter of the least important role in box I below and the letter of the most important in box V. Place the next two of least importance in box II and do the same for the next two most important in box IV. Then place the letters of the remaining roles in box III.

	____	____ ____ ____	____	
I Least Important	II Below Average Importance	III Average Importance	IV Above Average Importance	V Most Important

Question 19.3: What do you anticipate will be the importance of each of these roles in the future (three to five years)?

Instructions: Place the letter of the anticipated least important role in box I below, and the letter of the anticipated most important in box V. Place the next two of least importance in box II and do the same for the next two most important in box IV. Then place the letters of the remaining roles in box III.

	____	____ ____ ____	____	
I Anticipated Least Important	II Below Average Anticipated Importance	III Average Anticipated Importance	IV Above Average Anticipated Importance	V Anticipated Most Important

MANAGERIAL ROLE DESCRIPTIONS

A. The figurehead role: the chief executive is a symbol required by the status of his office to carry out a variety of social, legal, and ceremonial duties in which he represents the organization.

B. The leader role: the chief executive has interpersonal relationships with his subordinates; as he hires, trains, and motivates them, he must essentially bring their needs in accord with those of the organization.

C. The liaison role: the chief executive has interpersonal relationships with people outside of his own organization and spends a considerable amount of time developing a network of high-status contacts in which information and favors are traded for mutual benefit and through which the chief executive exerts community leadership.

D. The monitor role: the chief executive continually seeks and receives information about his organization in order to understand changing situations and his organization's environment.

E. The disseminator role: the chief executive shares some of the environmental information with his subordinates.

F. The spokesman role: the chief executive informs outsiders about the progress, problems, and activities of his organization.

G. The entrepreneur role: the chief executive takes the responsibility for bringing about changes in his organization, looking for problems and opportunities, and then initiating projects to deal with them.

H. The disturbance-handler role: the chief executive takes charge when his organization faces a major disturbance or crisis and deals with the resulting problems.

I. The resource allocator role: the chief executive decides who will get what in his organization; he establishes priorities, designs his organization, and authorizes all important decisions.

J. The negotiator role: the chief executive takes charge whenever his organization must enter into crucial negotiations with other parties; his presence is required because he has the information and the authority to make the decisions that difficult negotiations require.

20. To give us information about how duties are divided among yourself and others, please place a check mark (✓) in the appropriate column. (Check only one answer per line.)

Column headings have the following definitions:

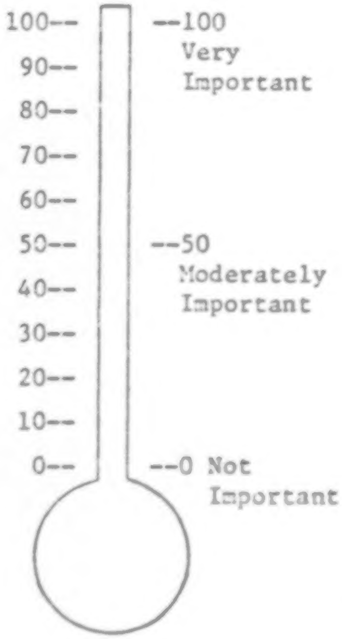
1. This activity is a primary duty of mine and is usually performed directly by me.
2. This activity is a responsibility of mine but is usually accomplished indirectly by my delegating it to others.
3. This activity is not a direct responsibility of mine but is performed by other individuals in the organization.
4. This activity is not performed by personnel in the organization.

	1 Performed directly	2 Accomplished indirectly	3 Performed by others	4 Not Performed
Group I:				
• Appoint administrative personnel	( )	( )	( )	( )
• Appoint department heads	( )	( )	( )	( )
• Approve promotions and transfers of department heads	( )	( )	( )	( )
• Coordinate personnel programs	( )	( )	( )	( )
• Develop personnel recruiting methods	( )	( )	( )	( )
• Direct personnel training programs	( )	( )	( )	( )
• Formulate personnel policies	( )	( )	( )	( )
• Negotiate labor union contracts	( )	( )	( )	( )
• Plan administrative office practices and procedures	( )	( )	( )	( )
• Resolve employee complaints and grievances	( )	( )	( )	( )
• Formulate wage and salary pay plans	( )	( )	( )	( )
• Evaluate training programs	( )	( )	( )	( )
• Evaluate managerial performance	( )	( )	( )	( )
• Plan and determine manpower requirements	( )	( )	( )	( )
• Direct and coordinate activities of nursing services	( )	( )	( )	( )
• Interpret changes in rules and regulations (governmental policies, for example) to organizational employees	( )	( )	( )	( )
Group II:				
• Analyze expenditures	( )	( )	( )	( )
• Negotiate financial agreements (insurance and facilities)	( )	( )	( )	( )
• Negotiate reimbursement rates with third party payers	( )	( )	( )	( )
• Prepare operations budget	( )	( )	( )	( )
• Review and revise budget allocations	( )	( )	( )	( )
• Conduct studies of financial performance and recommend changes	( )	( )	( )	( )

	1 Performed directly	2 Accomplished indirectly	3 Performed by others	4 Not Performed
• Approve purchases of expensive equipment	( )	( )	( )	( )
• Prepare administrative reports	( )	( )	( )	( )
• Search the organization and its environment for more efficient operations	( )	( )	( )	( )
• Recommend to the board the rates to be charged for services	( )	( )	( )	( )
• Solve cash flow problems	( )	( )	( )	( )
Group III:				
• Interpret policies, procedures, and regulations	( )	( )	( )	( )
• Investigate patient/resident complaints	( )	( )	( )	( )
• Represent organization on commissions, agencies, or at hearings	( )	( )	( )	( )
• Establish procedures for preparing and submitting reports	( )	( )	( )	( )
• Communicate health care needs to persons external to the organization	( )	( )	( )	( )
• Represent the organization in its relationships to other health agencies	( )	( )	( )	( )
• Assist medical staff with its organizational and medical-administrative problems and responsibilities	( )	( )	( )	( )
• Advise the board of trustees on matters requiring policy formulation	( )	( )	( )	( )
• Develop a long-range planning program for the organization	( )	( )	( )	( )
Group IV:				
• Contract for purchase and delivery of supplies and services	( )	( )	( )	( )
• Coordinate maintenance and repair activities.				
• Coordinate safety programs	( )	( )	( )	( )
• Enforce administrative policies and operating procedures	( )	( )	( )	( )
• Formulate health care policies	( )	( )	( )	( )
• Organize health care services	( )	( )	( )	( )
• Plan and determine health care quality standards	( )	( )	( )	( )
• Allocate organizational resources to achieve organizational goals	( )	( )	( )	( )
• Keep informed of legal changes affecting the organization	( )	( )	( )	( )
• Meet regulatory and accreditation requirements	( )	( )	( )	( )
• Write articles for professional journals of benefit to other administrators	( )	( )	( )	( )

21. From your point of view as an administrator, for each of the following kinds of goals, indicate the thermometer-scale number that expresses its importance in your organization.

Planning for expansion of patient care programs ___
Planning for expansion of facilities ___
High quality patient care ___
Coordination with community health care services ___
Recruitment and retention of professional staff ___
Development of harmonious interpersonal relationships among staff ___
Cost containment ___
Good community relationships ___
Good relationships with governmental agencies ___
Good relationships with third party payers ___
Teaching ___
Research ___
Shared services with other health care providers ___
Planned improvement of administrative services ___
Other (specify) ______________________________ ___
Other (specify) ______________________________ ___



22. Based upon your experiences, which skills and abilities should be developed by those in training to become health care administrators? (We would also like your insights and your thoughts regarding skills and abilities needed in the future by health care administrators.)

We would appreciate any comments you may have.

Thank you!